British Attitudes Towards Sexuality Of Men And Women With Learning Disabilities: A Comparison Between White Westerners And South Asians

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ABSTRACT

This study aimed to investigate public attitudes towards the sexuality of people with learning disabilities within a UK residing sample, and compare such attitudes between people from White Western and South Asian backgrounds. A mixed-method approach using an online questionnaire was employed. Three-hundred and thirty-one UK residing adults were recruited. Participants provided demographic details, completed five attitudes towards sexuality scales, in addition to measures of recognition and prior contact of a person with a mild learning disability. One of the sexual attitudes scales measured attitudes towards sexual openness in the typically developing men or women. The other four measured attitudes towards the sexuality of men or women with learning disabilities. These included four different aspects of sexuality (sexual rights, non-reproductive sexual behaviour, parenting and self-control). Participants completed either a male or female version of these scales. One open-ended question that asked about the sexuality of either men or women with learning disabilities was also included and responses to this question were analysed via a thematic analysis. Mean scores indicated that compared to White Westerners, South Asians had significantly more negative attitudes towards the sexual openness of men and women in the developing population and also towards the sexual rights of men and women with learning disabilities. Recognition was found to be poor in both ethnic groups, although White Westerners were found to be significantly more likely to be able to recognise mild learning disabilities compared to South Asians. These findings implicate the need to develop culturally sensitive interventions in improving knowledge and awareness of learning disabilities in addition to being aware of the differences in attitudes towards the sexuality of people with learning disabilities that may exist between different ethnic groups. These implications, the limitations of the study and suggested directions for future research are discussed.

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CHAPTER 1

INTRODUCTION

1.1: Synopsis

The Department of Health (DOH) has recognised that 'the needs of people from minority ethnic communities are often overlooked' (Valuing People, DOH, 2001, p.2). Additionally, the Royal College of Psychiatry (2011) has 'recognised the importance of attitudes and beliefs' and state that 'understanding the cultural and religious attitudes and beliefs plays a crucial role in determining the process of care' (p. 17). This research aimed to investigate public attitudes towards sexuality of people with learning disabilities. Specifically, the research aimed to quantitatively assess how these attitudes differed between people from White Western and South Asian backgrounds. The study addresses the current gap in knowledge about South Asian attitudes towards sexuality of people with learning disabilities. This is particularly important as given the increasing population of South Asian people within the UK, there is a need to understand how to provide culturally sensitive services for this community whilst also supporting all aspects life, including sexuality and parenting. This chapter provides a review of the existing theoretical ideas and research relevant to the present study.

The literature review starts with an overview of contemporary methods of diagnosis and understanding about learning disabilities. This leads to a consideration of how the conceptualisation of learning disabilities has been known to vary between

different cultures and time periods. Within the context normalisation and stigma theory, public attitudes towards people with learning disabilities are then discussed. This includes a review of the evidence that suggest differences in attitudes between people from White Western and South Asian backgrounds. Following this, research evidence that has specifically investigated attitudes towards sexuality of people with learning disabilities is reviewed. The final section provides an overview of the current understanding of South Asian attitudes towards sexuality of people with learning disabilities and this leads to describing the aims and hypotheses of the present study.

1.2: Defining terms

In order to keep the terminology consistent throughout this thesis, the term 'learning disabilities' has been used to describe the population of interest. This is because this is the term currently commonly used in UK health and social care systems. However, other terms frequently used to refer to people with learning disabilities such as 'intellectual disabilities' and "mental retardation' were used as search terms within electronic databases in order to capture the full scope of the literature available. The term 'White Western' has been used throughout to refer to people from White ethnic backgrounds living in Western countries. Although the present study employed only British residents, the term 'White Western' is inclusive to other people outside Britain, including White Irish, White European, White American and White Australian and these terms were also used search terms. Similarly, the term 'South Asian' has been used to refer to anyone originating from India, Bangladesh, Sri Lanka or Pakistan, although additional search terms such as 'British Asians', 'Indian,' 'Muslim,' 'Hindu,' and 'Pakistani' were used to capture the population of interest more widely within the literature.

1.3: Learning disabilities

1.3.1: Epidemiology and Diagnosis of Learning Disabilities

Researchers have identified that most learning disabilities are present at birth and if they are not, then they are known to have developed very early on in childhood (Carnaby, 2007). A precise figure of those known to meet the criteria for a learning disability is difficult to obtain due to a range of sampling methods, classification criteria and assessment methods. Nevertheless, Emerson and Hatton (2008) estimated that approximately 2% of the UK would fall into learning disability classification. Higher rates of mild learning disability have been found to be associated with poverty and those living in deprived urban areas (Emerson, 2012). This is in comparison to severe learning disabilities which appear to be more evenly distributed across different areas and socio-economic groups (Emerson & Hatton, 2008). There is also some evidence to suggest higher prevalence rates of severe learning disabilities in some South Asian communities (Emerson et al., 1997), although there has been some controversy and contradiction surrounding this evidence (Emerson & Hatton 2004; McGrother, Bhaumik, Thorp, Watson & Taub, 2002).

Watson (2012) identifies a number of different casual factors for learning disabilities. These are summarised to occur during four time periods: pre-conceptual, prenatal, perinatal and postnatal. Both genetic and environmental casual factors that may cause learning disability during these stages include parental genotypes, maternal health, infection, nutrition, toxic agents, prematurity, injury, untreated genetic disorders, trauma, and sensory and social deprivation. Such causative factors have been identified by science and research.

In order to aid the scientific study of the epidemiology of learning disabilities, classification systems have been developed to assist with conceptualising from a diagnostic framework. These are discussed in turn. All of these discussed classification systems differentiate learning disabilities from other related conditions including specific learning difficulties such as dyslexia, dyspraxia and developmental/social communication disorders such as autism. Whilst people with learning disabilities may have co-morbidity with such related conditions, not everyone with these related conditions would necessary meet the criteria for a learning disability.

In its recent edition, the Diagnostic and Statistical Manual of Mental Disorders (DSM-V; American Psychiatric Association, 2013) uses the term 'Intellectual Disability' to describe people with learning disabilities and uses of three classification criteria. Firstly, the individual must have significantly impaired intellectual functioning, which they define as an Intelligence Quotient (IQ) of 70 or below. Secondly, there must be evidence of impairments in adaptive functioning, and finally the onset must be before 18 years of age. Severity of a learning disability is determined by adaptive functioning rather than an IQ score.

More widely used within the UK for diagnosis of learning disabilities is The International Classification of Diseases (ICD-10; World Health Organisation [WHO], 1992). In its current edition, the ICD-10 uses the term "Mental Retardation" to refer to people with learning disabilities and describes this as a condition where there is an arrested or incomplete development of the mind resulting in an impairment of cognitive, motor or social skills. ICD-10 criteria also state that such impairments occur during the developmental period and that there is a potential for improvement of intellectual abilities and social adaption with training and rehabilitation. In 2015, the

revised version of this classification system, the ICD-11, will use the term “Intellectual Disabilities” in keeping with the DSM-V.

The Department of Health in England (2001) defines a learning disability as a condition that results in a person having a significantly reduced ability to understand new or complex information, learn new skills and cope independently. All these difficulties must be present before adulthood. In other words, having a learning disability is defined as someone who has, since childhood, impaired intelligence and impaired social functioning.

Finally, the British Psychological Society (BPS, 2000) captures these various classification systems of a learning disability with the use of three core criteria: Significant impairment of intellectual functioning, significant impairment of adaptive/social functioning and an age of onset before adulthood. All three criteria must be met for a person to be considered to have a learning disability.

The principle method of determining intellectual functioning involves using tests that are recognised to be reliable, valid and standardised. Such tests are based on a normal distribution of general intelligence. Impaired intelligence has been defined as performing more than two standard deviations below the population mean. For example, within the Wechsler Adult Intelligence Scale- Fourth UK Edition (WAIS-IV^{UK}; Wechsler, 2008), the mean score is 100 and the standard deviation is 15. Therefore, a score of more than two standard deviations below the mean corresponds to an Intelligence Quotient (IQ) of 69 or less and thus has been used as a ‘cut off’ mark to define impaired intelligence (BPS, 2001). Assessment of a person’s adaptive/social functioning would consider a person’s abilities in communication, self-care, independent home living, social/interpersonal skills, using community

resources, self-direction, functional academic skills, work, leisure and health and safety. In order to meet the criteria of impairment in this area, the person would require significant assistance in order to survive and adapt to their social and physical environment (BPS, 2001). Formal interviews with parents, teachers and carers, as well as more other formal structured observations are often used to assess adaptive/social functioning.

The concept of adaptive/social functioning is broad and is related to a person's age as well as the social-cultural expectancies associated with their environment at a given time. Furthermore, formal measures cognitive assessments such as the WAIS-IV^{UK} are limited in that they are based on Western conceptions of cognitive ability and are based on normative data from Western populations. Therefore validity during assessment is compromised when assessing people from diverse cultural and linguistic backgrounds (Walker, Batchelor & Shores, 2009). Before the availability and knowledge of modern science and contemporary diagnostic classification systems, there have been different beliefs over time and different cultures about the causes of learning disabilities. These differing beliefs are important to consider as they have influenced how people with learning disabilities were cared for and treated. Furthermore, evidence suggests that such historical and cultural conceptualisations of learning disability may still prevail within the multi-cultural societies that now exist in Western countries (O'Hara, 2003; Tilley, Walmsley, Earle & Atkinson, 2012).

1.3.2: Historical and cultural conceptualisations of learning disabilities

Sue and Sue (1999 as cited in O'Hara, 2003, p. 172) highlight the differences in values and belief systems within White and non-White cultures. Such differences appear to be polar opposites towards each other. In contrast to White cultures,

component values and beliefs within non-White cultures include collectivism, interdependence, values in communication (silence being respectful, importance of non-verbal communication and withholding strong emotions), a reliance on spirituality as a model of healing and belief in the spirit world, gaining honour via sharing and giving and the importance on extended family structures that involve hierarchical relationships. Such values and belief systems may therefore prevail in the way people from these cultures conceptualise learning disabilities.

Chinese cultures believe that learning disabilities are due to fate and may seek supernatural powers via prayer to ancestors (Cheng & Tang, 1995). Aspects of Middle Eastern cultures view disabilities as a punishment from heaven or caused by 'an evil eye.' Within Indian cultures and the Hindu religion, there is the belief in the law of Karma - being rewarded or punished for actions from your current or previous life during the journey of the immortal soul (Aminidav & Wellere, 1995). Hindu immigrants have been documented to speak about learning disability in accordance these spiritual and religious beliefs (Gabel, 2004). Reviewing all studies in the area of all differing cultural beliefs about learning disabilities is beyond the scope of this thesis. However, further research in this area within South Asian cultures have been discussed in later sections of this review (see sections 1.4.4 and 1.5.4).

Beliefs and knowledge about the causes of learning disabilities have also varied and changed over time within Western cultures. Arokiasamy (as cited in Nunkoosing, 2011, p.8) suggests that over time there have been various conceptualisations of disability including causes due to supernatural forces, a focus on attribution due to medical and natural causes and more recently, the development of the view that people with learning disabilities constitute an oppressed minority. European folklore in the Middle Ages down to the late 19th century viewed babies and children with

learning disabilities as “changelings.” It was believed that the real baby had been taken by demons, fairies or elves and replaced by the disabled child. The mother was believed to have to take very good care of the disabled child; otherwise her real baby would be harmed (Hafter, 1968). It is interesting to note that this belief actually promotes the care of the child with a learning disability.

The eugenics movement within the latter half of the nineteenth focused on the inheritance of learning disabilities and promoted fear within societies about those of ‘normal’ intelligence being outnumbered by the ‘mentally deficient’ or ‘feeble minded’ (Park & Radford, 1998, p.218). Positive eugenics encouraged the healthy to breed healthy offspring and in contrast, negative eugenics discouraged reproduction for people with learning disabilities (Rosen, 2006). This led to people with learning disabilities being excluded from society and institutionalised both within the UK and many other countries. Institutional care was a way of containing people who were perceived to be worthless and unable to contribute to society (Carnaby, 2007). Whilst the focus was on Institutional care within the UK, many countries adopted compulsory sterilisation laws (Tilley, Walmsley, Earle, & Atkinson, 2012).

Normalisation (Wolfensberger, 1972) has been a key principle in which people with learning disabilities have been conceptualised as an oppressed minority. Normalisation involves providing individuals with learning disabilities a life that can be part of society as close as possible (Nirje, 1980). This has led to the closure of institutions and the development of community learning disability services over the last 40 years. The principle of normalisation also became a way of encouraging services and communities to have a positive image towards and for people with learning disabilities (Wolfensberger, 1972). Normalisation principles within the UK have used O’Brien’s five service accomplishments which include the need for people

with learning disabilities to have community presence, choice, competence, respect and participation (O' Brien & Tyne, 1981).

Within the UK, normalisation has resulted in larger institutions being replaced by small grouped and staffed homes within the community (Mansell, 2006). The UK government's 'Valuing People'' and 'Valuing People Now' White Papers (DOH, 2001; DOH, 2009) have also been influential in the development of services for people with learning disabilities in order to maximise their social inclusion. These documents recognised the need for people with learning disabilities to lead fulfilling lives and introduced four key principles: rights, independence, choice and inclusion. The concept of 'supported living' for people with learning disabilities was also introduced in the early nineties. Supported living arrangements have allowed people with learning disabilities to have choices about how to live their lives. This includes choices to own or rent their homes and having control over the support required, who they will be living with and how they live their lives (Kinsella, 1993).

Whilst normalisation has had a positive influence within the UK, there have been criticisms towards the movement. For example, the views of people of with learning disabilities, power dynamics and the causes of social inequality and exclusion have not been considered within normalisation principles (Chappell, 1992). Additionally, whilst normalisation practices have led to community based residential provision, this has not always guaranteed better quality of care, quality of life or community integration (McVilly, Stancliffe, Parmenter & Burton-Smith, 2006; Scior, Potts & Furnham, 2013). With regards to inclusion within the community, people with learning disabilities have been found to experience discrimination and verbal abuse (Beart, Hardy & Buchan, 2005). Attempts in community inclusion have also been found only to result in physical inclusion as oppose to actual social inclusion (Cummins & Lau,

2003). Therefore people with learning disabilities still appear to be stigmatised in contemporary societies. Normalisation theory does not explain the causes of social inequality and exclusion towards people with learning disabilities. Theoretical models of stigma are able to account for these processes.

1.4 Stigma and public attitudes towards people with learning disabilities

1.4.1: Conceptualisation of stigma

It has been recognised that whilst theoretical models of stigma have been extensively developed within the mental health field, the application within the context of learning disabilities has received little attention (Scior & Furnham, 2011; Scior, Potts & Furnham, 2013; Werner, Corrigan, Ditchman & Sokol, 2012). A number of factors have been proposed to account for this disparity. These include the lower prevalence of learning disability compared to mental health problems, mental health problems being viewed as being more concerning for public health and because of the stigma towards people with learning disabilities being perceived as inevitable and impossible to change (Ditchman, et al., 2013). Nevertheless, it has been argued that the existing knowledge from mental health research can be used to aid our understanding stigma within learning disabilities (Ditchman, et al., 2013).

Goffman (1963) has been widely acknowledged for his research and conceptualisation of stigma. Goffman (1963, p.3) has defined stigma as an 'attribute that is deeply discrediting' that reduces the bearer 'from a whole and usual person to a tainted, discounted one'. Stigma has also been conceptualised as a social construction, relevant to a particular culture or time period, where groups of people are labelled (Jones et al,. 1984 as cited in Link & Phelan, p. 365). Link and Phelan

(2001) extended this conceptualisation and proposed that stigma exists within interrelated components including the labelling of differences, applying negative stereotypes, separation into categories, status loss and discrimination. Stigmatisation within this conceptualisation was proposed to arise when these interrelated components exist within situations where there are power differences between the individuals involved.

Stigma towards mental health difficulties have been proposed to operate at multiple levels. Ditchman et al. (2013) provided an overview of these levels which included stigma within social, institutional and individual levels. The process by which members of the general population endorse prejudice and discrimination is known as public stigma (Corrigan & Penn, 1999). Structural stigma involves the development of exclusion via discriminatory policies, laws and cultural norms and can be both intention and unintentional (Corrigan, Markowitz & Watson, 2004; Link & Phelan, 2001). For example, inaccessibility of public information for people with learning disability, whether intentional or unintentionally has been recognised as structural stigmatisation and a barrier to full inclusion (Yalon-Chamovitz, 2009). Within the context of the present study, structural stigma would include the inaccessibility of easy to read sexual health information for people with learning disabilities. Self-stigma has been viewed as a key process concept within the mental health literature (Ditchman et al., 2013). Self-stigma has been explained to occur when the members of a stigmatised group internalise the directed stigma towards themselves or their group. This results in various responses from these individuals or groups including low self-esteem and anger (Corrigan & Watson, 2002). Research within the learning disability literature has considered these interconnected aspects of stigma, although they have not always been explicitly referred to within studies.

1.4.2: Stigma and people with learning disabilities

There is no doubt that people with learning disabilities are stigmatised both publically and structurally, given the history of compulsory institutionalisation and sterilisation. Historical labels for people with learning disability such as 'Idiot' and 'moron' are considered ways of insulting people in modern society (Hastings, Sonia-Barne & Remmington, 1993). Understanding the public stigma towards people with learning disabilities has developed from investigations into stereotypes. People with learning disability have been found to be characterised via stereotypes of being dependent on others, childlike, happy and loving, and looking physically different (Gilmore, Campell & Cuskelly, 2003; McCaughey & Strohmer, 2005). This has resulted in public stigma being concerned with a combination of pity, dependency, discomfort and fear (Fiske, 2012; Jahoda, Wilson, Stalker & Cairney, 2010).

Qualitative studies that have interviewed people with learning disabilities themselves show evidence that people with learning disabilities are aware of public stigmatisation (Jahoda & Markova, 2004; Jahoda, Cattermole & Markova, 1988). Ditchman et al. (2013) argues that such research challenges the assumptions that people with learning disabilities are unaware of stigma due to their cognitive difficulties. Therefore, self-stigma is also important to consider in people with learning disabilities. The negative psychological effects of the internalisation of stigma in people with learning disabilities have been considered by researchers. For example, correlations have been found between greater perceived stigma and low self-esteem (Szivos-Bach, 1993) and people with learning disabilities have been proposed to have a greater risk of developing mental health problems due to stigmatisation (Caine & Hatton, 1998). However, such studies can be criticised on the grounds that causality has been assumed without the investigation of other contributory factors.

Stigma towards people with learning disabilities has also been studied via other related constructs such as attitudes towards community integration. Werner et al. (2012) proposed that one approach to understanding stigma is to view it as negative attitudes. Attitudes within social psychology theories are proposed to be composed of affective, cognitive and behavioural components (Chan, Livneh, Pruett, Wang & Zheng, 2009; Eagley & Chaiken, 2007). Whilst attitudes can be seen as positive or negative, stigma is concerned with negative attitudes (Corringan & Lundin, 2001). It has been recognised that positive attitudes towards people with learning disabilities are important in facilitating their full inclusion in society (Antonak & Livneh, 1991; Gilmore & Chambers, 2010; Henry, Keys, Jopp, Balcazar & Henry 1996). This is consistent with psychological theories that proposed that attitudes are consistently the best predictors of a range of intentions and behaviours (Ajzen & Fishbein, 1980). Therefore, we would expect more positive attitudes towards people with learning disabilities to be associated with more positive intentions and behaviours towards them, which would include those that are accepting of normalisation and social inclusion. A number of studies have investigated lay people's attitudes towards people with learning disabilities. Most of these studies have used direct attitude measures using opportunity sampling often with student samples.

1.4.3: Public attitudes towards people with learning disabilities

Scior (2011) conducted a systematic review on public awareness, attitudes and beliefs regarding learning disabilities. Seventy-five peer reviewed studies were identified between the years 1990-2011. Studies suggested an association between limited understanding of learning disabilities and negative attitudes. Although attitudes overall tended to be positive, the studies suggested that people with learning disabilities were the least desirable group to socially interact with when

compared to people with other physical and sensory disabilities (Gorden, Feldman, Tantillo & Perrone, 2004; Nagata, 2007; Westbrook, Legge & Pennay, 1993).

The systematic review identified a number of factors that were associated with more negative attitudes towards people with learning disabilities. These included, being older, having less education and having no previous contact with people with learning disabilities (Akrami, Ekehammer, Claesson & Sonnander, 2006; Antonak, Mulick, Kobe & Fiedler, 1995; Burge, Ouellette-Kuntz & Lysaght, 2007; Esterle, Sastre & Mullet, 2008; MacDonald & MacIntyre, 1999; Ouimet & de Man, 1998). Being male was also found to be associated with negative attitudes in these studies, although this finding was not consistently replicated in others (Hudson-Allez & Barrett, 1996; Karellou, 2003; Lau & Cheung, 1999; Nagata, 2007; Oullette-Kuntz, Burge, Brown & Arsenault, 2010).

Scior's (2011) review also identified studies that examined attitudes and casual beliefs in ethnic minority communities living in Western countries. This included a study in Australia that found very similar levels of stigmatising attitudes towards people with learning disabilities between six different ethnic communities including German, Anglo, Italian, Chinese, Greek and Arabic groups (Westbrook, Legge & Pennay, 1993). However, this finding was not reported to be consisted within other Western countries. For example, in a study that compared two groups within student samples, people from Japanese backgrounds were found to have less inclusion-friendly attitudes compared to North Americans (Horner-Johnson et al., 2002). Similarly in comparison to White British adults, Hong Kong residents were found to be less in favour of social inclusion for people with learning disabilities (Scior, McLoughlin & Sheridan, 2010). Whilst Scior's (2011) systematic review is helpful in understanding contemporary public attitudes towards people with learning

disabilities, the results should be interpreted with caution as there were a number of limitations in the studies that were reviewed. These include the recruitment of student samples that were unrepresentative of the wider population and the use of data that risked socially desirable responses when data was collected over the telephone.

To address some of these limitations, one study aimed to investigated stigma and public awareness about learning disability and attitudes towards inclusion among different ethnic groups within a sample that included 1002 ethnically mixed UK residents that were of working age (Scior, Addai-Davis, Kenyon & Sheridan, 2012). Participants in this study were asked to identify a diagnostically unlabelled vignette describing a man with mild learning disabilities. This was used to measure awareness and recognition of a learning disability and was followed by measures of social distance and attitudes to inclusion. In this study, just over a quarter of the sample (27.8%) were found to recognise typical symptoms of a mild learning disability and it was found that recognition and prior contact was associated with lower stigma and more positive attitudes. Ethnic group differences were also found. Ethnic groups that were recruited within the sample included White British groups (41%), South Asians (12.6%), Asians from other backgrounds (12%) and lastly black Africans (18.7%). White British participants were found to show increased recognition, lower stigma and more positive inclusion attitudes compared to participants from the other minority ethnic groups.

However, Scior et al.'s (2012) study was limited in that most participants were highly educated, and previous research has found higher education levels to be associated with more positive attitudes (Choic & Lam, 2001). Therefore, the findings in this study may not be representative of all attitudes from people with different levels of education. Furthermore, in their analysis, this study categorised all the non-white

participants within a broad label of “black and minority ethnic” as one homogenous group. Such a group of people from black and minority ethnic backgrounds would be representative of a diverse range of cultures and therefore may not differentiate those that belong to more collectivist cultures, where stigmatisation has been found to be more severe (Fung & Tsang, 2010; Kramer et al., 2002; Scior, Potts & Furnham, 2013).

Despite these limitations, such research has begun to develop our understanding of how attitudes towards people with learning disabilities differ between different ethnic groups and/or cultures. This is particularly important within the context of contemporary multi-cultural societies such as the UK as there may be practical implications in services developing cultural competence. This may include, for example, training staff to increase competence in cultural awareness, sensitivity and flexibility (Mir, Nocan, Ahmad & Jones, 2001).

One of the largest minority ethnic groups in the UK includes the South Asian population, which refers to people originating from India, Pakistan, Bangladesh and Sri Lanka (Modood et al., 1997). This ethnic group also includes Indian families that have lived in East Africa for a considerable time (Coles & Scior, 2012). This community forms 4% of the British population. The number of South Asian people with learning disabilities in the UK continues to rise. It has been estimated that by 2021, 7% of people with learning disabilities will be from South Asian ethnic backgrounds (Emerson & Hatton, 1999; Hatton, Akram, Shah & Emerson, 2003). This rise in numbers has been proposed to be not only due to rise in population of South Asians within the UK, but is also linked to the increase in prevalence of conditions that cause learning disabilities. These include genetic conditions such as thalassemia and autosomal recessive conditions associated with developmental

delays (Emerson et al., 1997, Hutcheson et al., 1998, Keer, 2001, Morton, Sharma, Nicholson, Broderick & Poyser, 2002; Shaw & Ahmed, 2004).

UK policies that promote independent living as part of social inclusion and normalisation for people with learning disabilities may not be of value to the cultural beliefs of people from South Asian backgrounds that are concerned with collectivist value systems (Miles, 1992). There appears to be a discrepancy between the need for services for South Asian families, given the increased number of South Asian people with learning disabilities, yet a low actual uptake of the support offered (Hatton et al., 2003; Chamba et al. 1999; Mir et al, 2001). This discrepancy may be due to differing attitudes and ideals between services and the South Asian community that they serve. One study in Leicestershire compared prevalence, morbidity and service need between South Asian and White adults with learning disabilities (McGrother, Bhaumik, Thorp, Watson & Taub, 2002). Whilst prevalence was not found to differ between Whites and South Asians, significantly lower use of services and lower skills were found within the South Asian sample. This suggests the need for services to be culturally sensitive and develop skill and community care for people with learning disabilities in South Asian families.

Reduced use of learning disability services from South Asian communities have also been proposed to be due to language barriers, lack of adequate information and understanding about the learning disability and lack of awareness about the support services that they were able to access (Hatton et al., 2003). Additionally, it has been identified that people from South Asian communities want more recognition of their culture and religion within learning disability services (Hatton et al., 2003). In order for services to address this need it is important for there to be an awareness and understanding about attitudes towards learning disabilities from South Asian

communities. An understanding of beliefs associated with ethnicity and culture are also important as they may influence attitudes and thus stigma towards people with learning disabilities (Fishbein, 1963, Werner el al, 2012).

1.4.4: South Asian beliefs & attitudes towards learning disabilities

Research has found differences in beliefs and attitudes towards learning disabilities between people from South Asian and White Western backgrounds. A large proportion of this research consists of qualitative studies that have employed interview methods. The following section aims to provide an overview of these studies. Most of these studies have investigated South Asian cultural or religious beliefs towards learning disabilities as oppose to direct measures of attitudes. However, beliefs are known to important in the formation of attitudes (Fishbein, 1963) so these studies have been considered relevant to the present study.

Fatimelehin and Nardishaw (1994) interviewed 12 White British and 12 South Asian families at an adult day centre for people with learning disabilities. This was with the use of a structured interview schedule which aimed to explore attitudes and beliefs about learning disabilities. This study found that compared to White British families, South Asian parents were less aware of what their child's problem was called, tended to believe in a spiritual or religious explanation or cause for their child's learning disability and wanted a relative to provide care when they were no longer able to provide it for themselves. This study also found that South Asian parents showed greater stigma and fear about the negative impact on the marriage prospect of siblings of their child with a learning disability. However, there were some limitations to this study including the use of a small sample size which has implications for the

application of the findings to a wider population. The sample also did not represent any South Asian families that classified their religion as Buddhist, Sikh or Christian.

One study that used a slightly larger sample size included a two year ethnographic study in the USA with 20 Hindu immigrants that were interviewed (Gabel, 2004). This study reported on the Hindu belief about 'punarjanma' which viewed learning disabilities as the result of sins from a past life. This religious view appeared to be positive about learning disabilities, as individuals would be expected to be "suffering through" an educational yet beneficial experience that may give them an opportunity to be released from rebirth (moksha). However, this study found little agreement on a common label 'mundh buddi' ('slow brain') used for people with learning disabilities. Some believed it to be a person with bad desires, others a problem in the brain that affects ability to learn and lastly there were a group that believed it referred to someone that was lazy or lacked desire.

Croot, Grant, Cooper and Mathers (2008) also used interviews in their study but focused on another sub-group of the South Asian community. This study recruited and interviewed 16 Muslim families of Pakistani origin. The study aimed to explore how Pakistani parents understood their child's learning disability. All 16 families were Sunni Muslims, although the authors noted variability in the sample in adherence to religious practices. Thematic analysis in this study identified a number of core themes. These included theological explanations for the child's learning disability where parents believed in either the child being a gift, test, punishment or for some other divine purpose. Parents also spoke about how other people in the community held beliefs about the child representing a curse from evil spirits, but these parents made it clear that they themselves did not share this belief. Another theme that emerged from the data was that all parents gave other explanations for causes of

their child's learning disability in addition to theological explanations including biomedical reasons and individual responsibility (actions during pregnancy). So overall, the Pakistani parents were found to hold a combination of beliefs including theological, medical and individual responsibility. Parents also described stigma within their own communities that led them to be reluctant to take their children to Pakistani community events. The authors noted a number of limitations in this study including that fact that the sample was a homogenous group in terms of representing only Sunni Muslims and no other religious traditions of Islam. Furthermore, all families consisted of parents that were born in Pakistan whose views may not be the same as British born Pakistanis. Another limitation within this study is that the focus was purely on the views of parents with a child with a learning disability, although some insights were obtained from community perspectives from their reports.

Recently, Coles and Scior (2012) conducted a qualitative study that compared attitudes towards people with learning disabilities between White British and South Asian people living within the UK. This study used relatively large sample sizes for a qualitative study. This included 31 South Asian and 30 White British sixth-form college students aged between 16-19 years. Data was collected via focus groups and individual interviews. Both ethnicities were shown to show poor levels of recognition and knowledge of learning disabilities, although South Asian participants appeared to show higher levels of confusion and were much less likely to recall media representations of learning disabilities. White British students also appeared to emphasise beliefs about choice and individuality for people with learning disabilities and this was not endorsed in South Asian participants. As with many qualitative studies, the sample size was small and views expressed may not apply to a wider population. Specifically, considering the homogenous age range within the study, the findings may not be representative of all age ranges within the two ethnic groups.

This is a significant limitation given that age has been found to influence attitudes towards people with learning disabilities (Scior, 2011).

Research that has taken place within India, Pakistan, Sri Lanka and Bangladesh have also found there to be poor knowledge about learning disabilities and stigmatising attitudes towards them. Furthermore, they have also documented causes of learning disabilities being attributed to both theological beliefs and biological beliefs and that these lead to a search for a cure via religious, spiritual or medical interventions (Murhty, Wig & Dhir, 1980; Mathur & Nalwa, 1987; Mandhavan et al, 1990; Venkatesan, 2004; Lakhan & Sharma, 2010). However, studying beliefs and attitudes within the South Asian countries of origin may not be applicable towards the South Asian population residing in Western countries due to the effect of acculturation.

Acculturation has been described as a process that occurs when individuals arrive and reside in a new culture and adjust to the values of the new culture (Redfield, Linkton & Herskovits, 1936). Therefore, the potential effect of acculturation needs to be considered in research when making generalisations about the views of South Asians residing in their country of origin towards those residing in Western countries. Whilst measuring acculturation can be difficult, proxy measures that have been used in previous studies have included length of residency (Ahrold & Meston, 2008). All the reviewed studies in this section are therefore limited in that they have not examined acculturation effects.

Additionally, most of the studies developing our understanding of South Asian perspectives of learning disabilities have been qualitative. Whilst qualitative methods provide a rich source of information, such approaches can be criticised for their lack

of objectivity and their ontological position in interpretivism. Qualitative approaches do not aim to obtain large samples that are representative of the wider population of interest. A universal approach to cross-cultural research has often been argued to be the most helpful middle ground paradigm (Berry, 1999). Universalism assumes that whilst all basic human characteristics are consistently portrayed internationally, it is cultural background that influences the meaning of these characteristics. A universal approach therefore would also consider quantitative as well as qualitative studies when comparing attitudes towards people with learning disabilities between Western and South Asian cultures.

To date, only one quantitative study that has compared South Asian and White British community living attitudes towards people with learning disabilities (Sheridan & Scior, 2013). A large sample of college students aged 16-19 (N = 737) were recruited for this study. People from South Asian backgrounds were found to have more stigmatising attitudes towards people with learning disabilities, a finding that is consistent to the previously discussed research studies. Also consistent with previous studies, it was found that being female and having prior contact with a person with learning disabilities was associated with pro-inclusion attitudes. This study has it strengths due to its large sample size and use of a well validated and reliable scale to measure community attitudes. The authors argued in favour of using an adolescent sample in that they represented a new generation of adults whose attitudes would impact on the future community of where people with learning disabilities live. However, it could also be argued that this in itself is a limitation as South Asian communities are always changing due to immigration and are not all second generation. Furthermore, limiting the age range of the sample makes the findings only generalisable towards this age group, as previous studies have found

age to be a factor that influences attitudes towards people with learning disabilities (Scior, 2011).

1.4.5: Section summary- stigma and attitudes towards people with learning disabilities

In summary, whilst theoretical and conceptual models of stigma have been limited in within the context of learning disabilities, they have been extensively considered within the field of mental health (Scior, Potts & Furnham, 2013; Scior & Furnham, 2011; Werner, Corrigan, Ditchman & Sokol, 2012). One way of conceptualising stigma is to view it as negative attitudes (Werner et al., 2012). A number of studies have investigated public attitudes towards people with learning disabilities. Evidence suggests that contemporary inclusion attitudes towards people with learning disabilities are generally positive (Scior 2011). A systematic review of studies in this area identified a number of factors known to be associated with more negative attitudes and these include a lack of knowledge, prior contact and ability to recognise a learning disability. Demographic factors also found to be associated with more negative attitudes include being older, having lower levels of education, being male and being an ethnic minority (Scior, 2011).

One of the largest ethnic minority groups within the UK includes those from South Asian communities (Modood et al., 1997). Most of our current understandings about the attitudes and beliefs towards learning disabilities within South Asian communities have been derived from qualitative research. These studies suggest that compared to White Westerners, South Asian people are more likely to endorse greater stigmatising attitudes towards people with learning disabilities. People from South Asian backgrounds also appear to have more theological beliefs surrounding the

causes of learning disabilities, but these beliefs also held with a combination of religious practices and beliefs about causes and cures via medical means (Fatimelehin & Nardishaw, 1994; Gabel, 2004; Croot, Grant, Cooper & Mathers, 2008). These qualitative studies are limited in their small sample sizes that have focused on particular homogenous groups of South Asians. A recent quantitative study has supported the findings of these qualitative studies as people from South Asian backgrounds were found to have more stigmatising attitudes towards people with learning disabilities compared to White Westerners (Sheridan & Scior, 2013). Although this study had a large sample size, it was limited to a convenience sample aged 16-19 years old, so the findings are not generalisable across all age groups. Furthermore, as with all the qualitative studies in this area, the effects of acculturation were not considered in this study.

Whilst demographic factors including ethnicity are important in predicting positive attitudes, the concept of "attitudinal ambivalence" and the "dual attitudes" model (Armitage & Conner, 2000; Wilson, Lindsey & Schooler, 2000) suggest that attitudes toward people with learning disabilities are made of a number of ideas that may be in conflict with each other (Coles & Scior, 2012). One area that may hold such specific attitudinal components include the sexual rights for persons with learning disabilities.

1.5: Sexuality and people with learning disabilities

1.5.1: Introduction to sexuality

The World Health Organisation (WHO, 2006) provides a comprehensive definition of sexuality which captures a broad range of dimensions suggesting sexuality should not be regarded as a single construct:

Sexuality is a central aspect of being human throughout life encompassing sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors (p. 5).

Therefore, for people with learning disabilities to be fully integrated into society and to live 'ordinary lives' we would expect social inclusion to also extend to the expression of their sexuality. A right to express sexuality has been argued to be an important part in the process of normalisation for people with learning disabilities (Aunos & Feldman, 2002). Research has shown sexual and romantic experiences are important for emotional wellbeing and that sexual interests are not known to depend on one's intellectual functioning (McCabe & Cummins, 1998; Konstantareas & Lunsky, 1997). People with learning disabilities have expressed their frustration towards denial of their sexual rights, including a lack of privacy necessary for intimacy (Hollomotz, 2009; Lofgren-Martenson, 2004; Healy, McGuire, Evans & Carley, 2009; Szollos & McCabe, 1995).

The next two sections provide an overview of both historical and contemporary perspectives on sexuality in people with learning disabilities. This is followed by overview of research that has looked at attitudes towards the sexuality of people with learning disabilities, including the current limited knowledge of South Asian perspectives. Knowledge about how sexual attitudes differ between ethnic groups is important in understanding how this area of life for people with learning disabilities is

stigmatised within the multi-cultural Western societies. This can lead to many useful practical implications for health professionals including the development of culturally sensitive interventions to reduce the stigma associated with the promotion of normal and safe sexual lives for people with learning disabilities.

1.5.2: Sexuality and people with learning disabilities

Historically, there have appeared to be two contradictory western beliefs about sexuality in people with learning disabilities. McCarthy (1999) documented how people with learning disabilities were either viewed as asexual 'eternal children' or individuals dangerous to society due to their promiscuity. Within the stereotype of being an 'eternal child', people with learning disabilities were thought to have the mind of a child and therefore protecting their innocence was seen as priority. The other stereotype, in contradiction, viewed people with learning disabilities as being a sexual threat to others due to their inability to control their sexual desires. These two beliefs, although contradictory, became '…powerfully held 'truths' which exerted powerful influence over attitudes to, and services for, people with learning disabilities" (McCarthy, 1999, p. 53-54). Furthermore, the eugenics movement in the late 19th and early 20th centuries promoted fear about the biological inheritance of learning disabilities. This led to compulsory sterilisation laws and, as was more prominent within the UK, same sex institutionalisation (Barker, 1983; Blacker, 1950 as cited in McCarthy, 1999, p.54).

Following a pamphlet produced by the Kings Fund Centre (1980) "An ordinary Life" a number of policies have attempted to reinforce practices that enable people with learning disabilities to have the same equal opportunities and enjoyment in life. However, only a few of these policies have been explicit about the need to think

about sexuality and sexual expression for people with learning disabilities. Nevertheless a number of initiatives within the UK have aimed to address this area. Person-centred planning has been important in giving opportunities for people with learning disabilities to develop personal relationships although Robertson et al. (2006) noted that this approach is not always sufficient. Assisting people with learning disabilities to develop sexual and personal relationships have been proposed to be part of the 'holistic care model of care' in nursing practices (Earle, 2001). Sexual education and learning programmes are now available for people with learning disabilities such the 'Living Your Life Pack' (Bustard, 2003). Efforts have also been made in enhancing the capacity of people with learning disabilities to make sexuality related decisions and providing further opportunities to develop friendships (Dukes & McGuire, 2009).

Another part of the enjoyment and opportunities of normal sexual and personal relationships is the opportunity of parenthood. It has been recognised that parenting difficulties in people with learning disabilities are not only due to their cognitive limitations. For those with an IQ of 60 and above, there is no direct link between a person's IQ score and parenting ability (The International Association for Scientific Studies of Intellectual and Developmental Disabilities [IASSID] Special Interest and Research Group [SIRG] on Parents and Parenting with Intellectual Disabilities, 2008). Despite this, parents with learning disabilities are more likely than other groups of parents to have their child removed by social care services (Booth, McConnell & Booth, 2006).

Attitudinal social factors towards parenting and related experiences that lead to discrimination and stigmatisation may affect psychological wellbeing (Feldman, Varghese, Ramsay & Rajska 2002). For example, when people with learning

disabilities announce pregnancies, this is often received with disbelief and dismay from family, friends and the community as oppose to an event to be celebrated (Llewllyn, 2002; Booth & Booth, 1995). Some parents are faced with assumptions of others that the pregnancy was not planned and are pressured in having abortions (Mayes, Llewellyn & McConnel, 2006). In order to cope with the distress of stigmatisation, people with learning disabilities may adopt strategies to appear that they are coping with the demands of parenting. This has been described in the literature as taking on a 'cloak of competence' (Edgerton & Bercovici, 1976) and this may actually perpetuate parenting difficulties in people with learning disabilities (Feldman et al., 2002). Evidence suggests that the social support provided is actually the most influential factor in successful parenting for people with learning disabilities (Feldman et al., 2002). This suggests a need for services to engage people learning disabilities and support them with accessing services that provide them with practical and skill based learning in parenting. In a review of services, Tarleton et al. (2000) found that there was a wide range of support available to families where one or more of the parents had a learning disability. However the support available has been found to be inconsistent across the UK by the Commission for Social Care Inspection (2009).

As discussed within earlier section of this chapter, attitudes are important to consider for understanding how people with learning disabilities are stigmatised. A number of studies have specifically investigated attitudes towards the sexuality of people with learning disabilities. These studies have used both lay populations and specific groups such as carers of a person with learning disability as well as residential staff, healthcare professionals and other community leisure workers.

1.5.3: Attitudes towards sexuality of people with learning disabilities

Aunos and Feldman (2002) reviewed studies from the 1970's, 1980's and 1990's that investigated attitudes from different groups of people towards sexuality, sterilisation and parenting rights for people with learning disabilities. Professionals that worked with people with learning disabilities were generally found to have more conservative attitudes. Studies indicated that sexual behaviours such as hugging and brief kissing were more accepted compared to more intimate sexual relations (Mitchel, Doctor & Butler, 1978; Craft & Craft 1981; McCabe, 1993; Owen, Griffiths, Feldman, Sales & Richards, 2000; Trudel & Desjardins, 1992). The studies also confirmed that parents of children with learning disabilities held conservative attitudes (Brantlinger, 1985; Alcorn, 1974). These findings were in contrast to special education teachers and University students that were found to have more positive sexual attitudes towards with learning disabilities (Brantilinger, 1992; McEwen, 1977; Bemish, 1987; Hagen, Powell & Adams, 1983). As for views from people with learning disabilities themselves, it was found that they too had conservative attitudes (Owen et al., 2000), which were more conservative than typically developing undergraduate students (Lunsky & Konstantareas, 1998).

The review also concluded that attitudes towards marriage and parenting in people with learning disabilities were generally negative from parents and special education teachers (Alcorn, 1974; Whitcraft & Jones, 1974; Wolf & Zafras, 1982; Leyser & Abrams, 1982; Brantilinger, 1992; Wolfe, 1997). Service workers felt that that people with learning disabilities should have the right to marry and have children but only if they had the ability to work and take on other adult responsibilities (Coleman & Murphy, 1980). However, other later studies suggested that service workers favoured sterilisation and that they had major concerns if people with learning disabilities were

to marry and have children (Brantlinger, 1992; Wolfe, 1997). A large percentage of people with mild learning disabilities were able to express their desires to marry and raise a child (David, Smith & Friedman, 1974; Brantlinger, 1985; Bass, 1978) and whilst many of were against both abortion and adoption, although the latter was viewed as a more acceptable solution (Bratlinger, 1985).

Aunos and Feldman (2002) acknowledged in their review that much of the attitude research they had discussed was outdated and they recommended future studies to continue to update contemporary perspectives. The following year, Yool, Langdon and Gardner (2003) aimed to investigate sexual attitudes of staff within a medium secure unit towards adults with learning disabilities with use of a qualitative approach. Four interviews were conducted with staff that included members of both sexes. Analyses involved identifying themes from transcribed interviews. This revealed that overall staff members held liberal attitudes towards sexuality and masturbation. However, less liberal attitudes were held regarding specific aspects of sexuality including sexual intercourse, homosexual relationships and involvement of people with learning disabilities in sexuality decisions. However this study is limited by the small sample size of service staff which may not represent the attitudes of a larger population. A number of more recent quantitative studies have addressed these limitations and employed larger sample sizes. The following section reviews these studies.

Cuskelly & Bryde (2004) investigated attitudes towards the sexuality of adults with learning disabilities by comparing the attitudes of three samples in Australia which included parents of an adults with a learning disability (*n* = 43*)* , support staff (*n* = 62*)* and a community sample (*n* = 63). An attitude scale was developed to measure attitudes by collating items from previously developed instruments. This has become

known as the Attitudes to Sexuality Questionnaire- Individuals with an Intellectual disability (ASQ-ID). The ASQ-ID covered eight different areas of sexuality including sexual feelings, sex education, masturbation, personal relationships, sexual intercourse, sterilisation and parenthood. This study found that attitudes amongst all groups of participants were overall generally positive. However, older participants were found to have less liberal views and parenthood was considered less positively than other aspects of sexuality in all groups. These latter two findings are consistent with the findings of previous research (Murray & Minnes, 1994; Oliver, Anthony, Leimkuhl & Skillman, 2002; Yool, Langdon, & Garner, 2003). Cuskelly & Bryde (2004) recommended developing the ASQ-ID via an examination of factor structure to ascertain whether attitudes to the sexual expression of a person with a learning disability were unidimensional and also to examine sexual expression of men and women separately.

Following these recommendations, Cuskelly and Gilmore (2007) further develop the ASQ-ID by obtaining community norms in Australia. This led to gender specific versions of the ASQ-ID being developed and four factors being extracted. These factors included sexual rights, parenting, non-reproductive sexual behaviour and self-control. The authors also developed a shorter measure that aimed to assess attitudes in typically developing male and females. This became known as the Attitudes towards Sexuality Questionnaire- Individuals from the General Population (ASQ-GP). This modified version of the ASQ-ID and the new ASQ-GP was administered to a community sample of 261 participants that were found to representative of the Australian population in terms of demographic characteristics. A significant effect of age was found where older people had less accepting views on the sexual rights of people with learning disabilities. The results also suggested that older participants were more likely to believe that people with learning disabilities are

less unable to control sexual urges. Overall, attitudes to most different areas of sexuality was positive but more negative attitudes were evident within subscales that asked about parenting and non-reproductive behaviour in people with learning disabilities. When considering the differences in attitudes towards male versus female sexuality, a significant effect was only found for the self-control measure. Males with a learning disability were perceived to have greater difficulty in controlling their sexual behaviour than were females. The attitudes towards sexuality in typically developing adults, as measured by the ASQ-GP, were also shown to be different dependent on the gender of the respondent. Women were more positive about sexual openness than men. When comparing scores from the ASQ-GP and ASQ-ID, the data suggested that community attitudes towards sexuality in typically developing adults were more acceptable than those with learning disabilities.

The ASQ-ID and ASQ-GP has also been used to measure and compare sexual attitudes towards learning disabilities from disability support staff and leisure industry employees (Gilmore & Chambers, 2010). As with previous studies, participants in this study were found to overall have positive attitudes towards the sexuality of individuals with learning disabilities. No differences were found between the support staff and leisure workers in their attitudes towards sexual rights, non-reproductive sexual behaviour or self-control. However a difference was found in the parenting subscale in which support staff were found to hold more conservative attitudes (less positive). Support staff scores also suggested that they had more positive attitudes towards sexuality in in typically developing adults compared to people with learning disabilities. As was found in Cuskelley & Gilmore's (2007) study, within both groups of participants, males were viewed as having less self-control than females. No other differences were found in the other attitude subscales towards the sexuality of men and women with a learning disability.

The ASQ-ID and ASQ-GP are also beginning to be used in different countries. Meaney-Taveres & Gavdia-Payne (2012) used these measures to further investigate the role of staff characteristics on sexual attitudes towards people with learning disabilities in an Australian sample. Participants included sixty-six staff that were employed with various day and community services for people with learning disabilities in Melbourne. As with the previous studies, sexual attitudes were generally positive although they were more negative towards people with learning disabilities than towards people in the typically developing population. Staff attitudes were also found to be more positive towards the sexual rights, non-reproductive sexual behaviour and self-control in women with learning disabilities, in comparison to men with learning disabilities. This is a novel finding compared to both Cuskelly and Gilmore's (2007) and Gilmore and Chambers' (2010) studies which found this difference to only occur on the self-control scale. Sexual attitudes from younger staff and direct staff were found to be more liberal as has been consistently found in previous studies (Aunos & Feldman; Gilmore & Chambers, 2010; Cuskelly and Gilmore's, 2007). Lastly, staff that had completed sexuality training were found to have more positive attitudes towards parenting for both men and women with learning disabilities and non-reproductive sexual behaviour in men.

To date, the most recent study in this area has taken place within Canada. Saxe and Flanagan (2014) compared support workers and non-support workers attitudes towards sexuality in people with learning disabilities. Measures used included the original version of the ASQ-ID and the Perceptions of Sexuality Scale (POS) devised by Scotti, Slack, Bowman & Morris (1996). No differences in sexual attitudes were found between the support worker group and the comparison group. Key findings included an association between positive attitudes and no religious affiliation and higher educational level. More conservative sexual attitudes towards the typically

developing population have been found to be associated with those that are more religious (De Visserur, Smith, Richters & Risse, 2007). Saxe and Flanagan's (2014) study has it strengths in being novel by investigating this factor in reference to the learning disability population. However, the study was limited due to the small sample sizes and the fact that participants were either Christian, Jewish or stated that they had no affiliation with religion. Therefore further research would benefit from including participants from a larger variety of religious backgrounds. Furthermore, another limitation of all the discussed studies that have investigated sexual attitudes towards people with learning disabilities is that they have focused on White Western population and have not considered how attitudes may differ within the residing ethnic minority communities.

Public attitudes towards such different aspects of sexuality in people with learning disabilities may also vary due to different cultural beliefs associated with particular ethnic groups. To date, no studies have investigated the effect of these factors on sexual attitudes specifically towards people with learning disabilities. As identified earlier on in this chapter, the South Asian ethnic group is particularly worthy of study within the UK being the one of the largest ethnic groups and due to high need from these communities but low uptake of services (Hatton, Akram, Shah & Emerson, 1997; Chamba et al., 1999; Mir et al., 2001). Our current, though limited, understanding about how attitudes towards the sexuality in people with learning disabilities from the South Asian attitudes is discussed in the next section and this naturally leads to the aims and hypotheses of the present study.

1.5.4: Sexuality and learning disabilities: South Asian perspectives

As reviewed earlier, research has informed us about differences in belief systems that exist between South Asian and Western cultures and how these impact upon perspectives of learning disabilities, including attitudes towards community inclusion. However, few studies have specifically aimed to understand South Asian perspectives *on the sexuality* of people with learning disabilities. This section has drawn upon the limited knowledge in this area, including what is known about South Asian perspectives on sexuality in the typically developing population and also the previously discussed research on South Asian conceptualisation and inclusion attitudes towards people with learning disabilities.

Griffiths et al., (2011) analysed data that investigated South Asian attitudes and experiences of sexual learning and first intercourse within the typically developing population. South Asians, including Indians (*n* = 393) and Pakistanis (*n* = 365) were compared to responses from a British general population (*n* = 12110). Data was obtained from a larger probability survey. People from South Asian ethnic groups were more likely to believe that pre-marital sex was wrong and were more likely to be married at the time of first sex. It was also found that women from South Asian backgrounds were less likely to discuss sex with parents during adolescence. A similar finding has been reported in a study in rural Bangladesh, where parents avoided discussing sexuality with their children and such discussions took place with peers (Aziz & Maloney, 1985). Research has also found that certain South Asian faiths also view other aspects of expressing sexuality such as masturbation as shameful (Davidson, 2000; Meston, Trapnell & Gorzalka, 1998). Furthermore, studies have suggested that women in South Asian cultures are expected to be more restricted in their sexuality compared to men (Ghule, Balaiah, & Joshi, 2007; Menon,

1989). Therefore, the evidence indicates that people from South Asian backgrounds have conservative attitudes towards sexuality in the typically developing population. Limited research has taken place which informs us about how these belief systems may prevail in South Asian attitudes towards the sexuality of people with learning disabilities.

One qualitative study discussed some sexuality issues raised by an arranged marriage of a Bangladeshi girl with a learning disability called Amina (Hepper, 1990). Parents and relatives of Amina believed that marriage and having children would allow her to get on with her life and overcome her cognitive difficulties. Amina's father believed that her learning disability was treatable and that she would be able to move away and live with her husband in the future. Both parents were positive about the prospect of married life for Amina and anticipated children from the marriage. Similarly, Summers and Jones (2004) reported on the case of Mubaraq, a young man in his twenties with learning disabilities. His family were keen for Mubaraq to be married and believed that in doing so would mean a good standing in their community. The family also felt that Mubaraq's wife would take on a caring role for Mubaraq. Other studies have also been consistent in documenting how people from South Asian backgrounds view marriage and children as a positive future prospect in people with learning disabilities and as something that would provide them with a cure (Baxter, 1990; O'Hara & Martin, 2003; Sheridan & Scior 2013). However, studies have not explicitly explored South Asian attitudes towards other aspects of sexuality in relation to people with learning disabilities.

1.5.5: Section summary - sexuality and people with learning disabilities

In summary, sexuality is a broad construct (WHO, 2006) that incorporates many aspects of life. Allowing people with learning disabilities to express their sexuality has been recognised to be important in allowing them to fully integrated within society (Aunos & Feldman, 2002). Contemporary perspectives suggest that Western Societies have become more liberal towards the sexuality of people with learning disabilities. This is further reflected in the progress that has been made in ensuring people with learning disability are able to express their sexuality (Bustard, 2003; Dukes & McGuire, 2009; Earle, 2001; William, 2001). However, stigma may still exist towards the sexuality of people with learning disabilities (Booth, McConnell & Booth, 2006; Hollomotz, 2009; Lofgren-Martenson, 2004; Bernet, 2010; Healy, McGuire, Evans & Carley, 2009; Szollos & McCabe, 1995; Feldman, 2002, Booth & Booth, 1995; Mayes, Llewllyn & McConnel, 2006; Llewllyn, 1994)

The importance of the study of attitudes for understanding stigma and negative attitudes towards people with learning disabilities has been discussed within earlier sections of this chapter. A number of empirical studies have aimed to investigate public attitudes towards different aspects of sexuality in people with learning disabilities. These have found that attitudes towards sexuality in people with learning disabilities are generally positive from people within the community, care staff at community homes and people from other public services (Cuskelly & Bryde, 2004; Cuskelly & Gilmore, 2007; Gilmore & Chambers, 2010). However, these attitudes are less positive when compared to sexual attitudes towards typically developing adults. There appears to be an effect of age, where older people hold more conservative attitudes. Males with learning disabilities are also perceived to have less ability in being able to control their sexual behaviours compared to females, although a recent

study found this difference to also occur towards sexual rights attitudes and attitudes towards non-reproductive behaviour (Meaney-Tavares & Gavidia-Paye, 2012). Attitudes concerned with parenting in people with learning disabilities have been found to be less accepting, particularly within staff members that work with people with learning disabilities (Cuskelly & Gilmore, 2007). A recent study has indicated that people who are more religious are more likely to have more conservative sexual attitudes in general and towards people with learning disabilities (Saxe & Flanagan, 2014).

It has also been recognised that whilst people from South Asian communities are more conservative in their attitudes towards sexuality in general (Aziz & Maloney, 1985; Davidson, 2000; Griffiths et al., 2011; Meston, Trapnell & Gorzalka, 1998), aspects such as marriage and parenting for people with learning disabilities may not have the same taboos associated with Western attitudes. Studies have indicated that people from South Asian communities expect people with learning disabilities to get married and have children (Baxter, 1990; Hepper, 1990; O'Hara & Martin, 2003; Sheridan & Scior, 2013; Summer & Jones, 2004). Most studies in this area have been qualitative that have obtained information via interviews from only parents with a child with learning disabilities. Whilst case studies have provided useful insights, conclusions drawn may not generalise to the wider South Asian population. Furthermore, these investigations have not specifically aimed to obtain an understanding of South Asian attitudes towards different aspects of sexuality in people with learning disabilities. The present study therefore aimed to address this gap in the literature.

1.6: The present study

1.6.1: Aims & rationale

The rational for this study was concerned with the need for further quantitative research to develop knowledge and understanding about how the effects of cultural beliefs within South Asian communities influence attitudes towards the sexuality of people with learning disability. Obtaining such an understanding is important for the development of culturally sensitive interventions that address sexuality issues and associated stigma for service-users with learning disabilities and their families. The present study achieved this by conducting a quantitative study that measured attitudes towards sexuality in people with learning disabilities from a lay population and assessed differences in these attitudes between people from White Western and South Asian backgrounds. This was with the use of the previously discussed ASQ-ID and ASQ-GP measures. Additionally, the present study aimed to test specific hypotheses about differences in attitudes between the two ethnic groups on different aspects towards the sexuality of men and women with learning disabilities. These hypotheses were based on current knowledge from the reviewed research.

1.6.2: Hypotheses

Five hypotheses were proposed:

1. British South Asians will have more negative attitudes towards the sexuality of both men and women in the typically developing population (less sexual openness) than British White Westerners.

2. British South Asians will have more negative attitudes towards sexual rights of both men and women with learning disabilities compared to British White Westerners.

3. British South Asians will have more negative attitudes towards non-reproductive sexual behaviour of both men and women with learning disabilities compared to British White Westerners.

4. Compared to British White Westerners, British South Asians will have more positive attitudes towards parenting rights of men and women with learning disabilities.

5. Both ethnic groups will view men with a learning disability as having less self-control of their sexuality than women with a learning disability.

The hypotheses were proposed to be supported when potential covariates of age, gender, education, prior contact and recognition were accounted for. Sexual openness in general was also considered as a covariate for controlling the effects of conservative sexual attitudes in general for hypotheses 2-5.

CHAPTER 2

METHODS

2.1: Design

This study employed mainly a quantitative approach that measured attitudes towards sexuality using the ASQ-GP and ASQ-ID. UK residing adult White Western or South Asian participants completed either a female or male version of the two scales. Demographic information was also collected in addition to a corresponding male or female measure of recognition of a mild learning disability. Participants were also asked about whether they had previously met a person with a learning disability. The main factors of interest in this study where those concerned with between subject effects (ethnicity and questionnaire version).

2.2: Ethical Procedures

2.2.1: Approval

The study, although addressing a clinical topic, did not require NHS ethics approval as participants were not NHS patients or recruited via NHS services. Full ethical approval was applied for and granted by the Royal Holloway Psychology Department's ethics committee (see appendix 1 for copy of approval email p.140). Ethical issues that were considered included confidentiality of information, potential for mild distress if some of the some questions were perceived to be

sensitive/embarrassing, rights to withdraw without reason and informed consent. Debriefing was not proposed to be required for this study because it was anticipated that as participants progressed through the questionnaire the purpose of the study would be clarified. Nevertheless, participants were invited to contact the researcher or the research supervisor via email (details provided on the first and last page of the questionnaire) if they had any further queries. Only two participants contacted the researchers, one of whom asked about whether they were eligible to participate and the other about when the prize draw would be taking place.

The identified ethical issues were addressed via an informed consent procedure that was presented to participants before they confirmed their consent to participate (see Appendix 2 p.141-142).

2.2.2: Informed Consent Procedure

The information page informed participants that the study aimed to gain an understanding of public attitudes towards sexuality and parenting in the general population and towards specific groups of people. Participants were not informed at this stage that there would be questions asked about learning disabilities as this would have invalidated the recognition measure. Participants were reminded that their participation was voluntary and that they were free to withdraw at any time without reason.

As some of the questions were potentially sensitive subjects for participants, they were reassured of their confidentiality and anonymity of their responses and encouraged to give honest answers. The online methodology also addressed this issue as it gave participants an opportunity to participate within their own private

space. Further to feedback from the ethics committee, participants were informed that they had the option to omit answers to questions should they prefer not to answer.

Participants for this study were incentivised via a prize draw entry for a £50 Amazon voucher. Participants were therefore also reminded that the email address they were asked to provide at the end of the study in order to enter this prize draw was also confidential and would be stored separately and not associated with the other questionnaire data. Information about the storage and disposal of data was also presented. Informed consent was assumed via a 'confirmation to consent by proceeding' statement on an online consent page (see Appendix 2 p.142).

2.3: Participants

2.3.1: Sample

The total sample consisted of 331 adult (18+) participants living in the UK. Most were recruited online via social networking websites. Six participants were recruited and completed paper versions of the questionnaire at a local town centre. Inclusion criteria for the study required participants to be a UK residing adult that described themselves belonging to a White Western or South Asian ethnic group. Participants were asked to confirm this on the consent page. Further details of participants, including a descriptive statistics of the demographic characteristics of the sample can be found in the result chapter (section 3.3.1 p. 70-78).

2.3.2: Power Analysis

A calculation of the required sample was undertaken a priori via a power analysis. This was informed from a recent study by Sheridan & Scior (2013) where a medium effect size of 0.3 was found in their study. This study, although did not compare attitudes towards sexuality, did compare attitudes towards people with learning disabilities including perspectives on marriage between White Westerners and South Asians. Therefore, this study was the closest in relevance to the current study. Based on this medium effect size a power calculation was carried out using the tables as cited in Clark-Carter (1997). The alpha level was specified at 5% and desired power at 80%. This analysis calculated a required total sample size of 140. This required 70 people from each of the two ethnic groups for each questionnaire version. Therefore, a minimum of 280 participants were required. Although fewer South Asian participants were recruited than White Westerners the minimum target total sample sizes were achieved within each ethnic group.

2.4: Measures

2.4.1: Attitudes towards sexuality of typically developing men and women

The ASQ-GP (Cuskelley & Gilmore, 2007) was also used to measure attitudes towards sexual expression in typically developing adults (adults without learning disabilities). Cuskelley & Gilmore (2007) developed the ASQ-GP specifically for this purpose and described it as an abridged version of the ASQ-ID containing two scales: Sexual Openness (7 items) and Timing (2 items). Only the 7 items measuring sexual openness where used in the study as this component was reported to have high internal consistency at 0.84 by the authors. The ASQ-GP also has a male and

female version. Figure 1 shows the actual questions corresponding to each subscale of the male version of the ASQ-GP. The same questions were used for the female version, with the words “boys”, “male” and “men being replaced with “girls”, “female” and “women” respectively.

Figure 1:

Items corresponding to the male version of the ASQ-GP (Sexual Openness scale)

Items- Sexual Openness
2 Boys should be discouraged from masturbating (R)
3 Discussions on sexual intercourse promote promiscuity in boys (R)
4 Sex education for boys has a valuable role in safeguarding them from sexual exploitation
5 Consenting male adults should be allowed to live in a homosexual relationship if they so desire
7 Advice on contraception should be fully available to young men
8 Sex education for boys should be compulsory
9 Masturbation in private is an acceptable form of sexual expression for men

Notes:

1. *R = reverse score items.*

2.4.2: Attitudes towards sexuality of men and women with learning disabilities

The most recent revision ASQ-ID (Cuskelley & Gilmore, 2007) was used in the present study. This appears to be the only validated measure that specifically measures attitudes towards the sexuality of people with learning disabilities. The ASQ-ID was developed from an earlier scale that was devised by Cuskelley & Bryde (2004) following their pooling of items from previous developed instruments (Fischer, Krajicek & Borthich, 1973; Mulhern, 1975; Parsons, 1982; Sweyn-Harvey, 1984).

Cuskelley & Gilmore (2007) developed the ASQ-ID further into two versions where one asked about attitudes towards sexuality in females with a learning disability and

the other version asked about males. Both versions comprise of the same questions but refer to either males or females. Participants are required to respond to their level of agreement with use of a 6-point Likert scale. Each question is scored between 1 and 6, with higher scores indicating more positive/ liberal attitudes. Following Cuskelley and Gilmore's (2007) factor-analysis, 6 items where dropped and four subscales were identified. These included Sexual Rights (13 items), Parenting (7 Items), Non-reproductive sexual behaviour (5 items) and Self-Control (3 items). These subscales were demonstrated to have high test-rested reliability ($r = 0.91$) and good internal consistency ($\alpha > 0.90$). Figure 2 shows the actual questions corresponding to each subscale of the male version of the ASQ-ID. The same questions were used for the female version, with the word "men" replaced with "women." The only modification made to the scale, with permission from the authors, was that the term "intellectual disability" was replaced with "learning disability" to correspond with British terminology that is better suited to a UK population.

Each participant completed either measures asking about the sexuality of males or measures asking about the sexuality of females for both the ASQ-GP and ASQ-ID (questionnaire version was a between-subjects factor). This was in order to prevent fatigue effects from the completing a long questionnaire and biases of order effects. Furthermore, it prevented participant reactivity and social desirable responses. For example, if given both versions, participants may have attempted to show equality in their attitudes towards males and females.

Figure 2*: Items corresponding to subscales on the male version of the ASQ-ID*

Subscale		Items
Sexual Rights		
	2	Provided no unwanted children are born and no-one is harmed, consenting adult men with a learning disability should be allowed to live in a heterosexual relationship
	5	Men with a learning disability have less interest in sex than do other men (R)
	10	Discussions on sexual intercourse promote promiscuity in men with a learning disability (R)
	13	Men with a learning disability typically have fewer sexual interests than other men. (R)
	15	Men with a learning disability are unable to develop and maintain an emotionally intimate relationship with a partner (R)
	16	Sex education for men with a learning disability has a valuable role in safeguarding them from sexual exploitation
	17	In general, sexual behaviour is a major problem area in management and caring for men with a learning disability (R)
	18	Sexual intercourse should be permitted between consenting adults with a learning disability
	19	Group homes or hostels for adults with a learning disability should be either all male or all female, not mixed (R)
	22	Men with a learning disability have the right to marry
	26	Advice on contraception should be fully available to men with a learning disability whose level of development makes sexual activity possible
	28	Marriage between adults with a learning disability does not present society with too many problems
	32	Marriage should not be encouraged as a future option for men with a learning disability (R)
Parenting		
	1	With the right support, men with a learning disability can rear well-adjusted children
	6	If men with learning disabilities marry, they should be forbidden by law to have children (R)
	11	Men with a learning disability should only be permitted to marry if either they or their partners have been sterilised (R)
	20	Care staff and parents should discourage men with a learning disability from having children (R)
	25	Sexual intercourse should be discouraged for men with a learning disability (R)
	29	Sterilisation is a desirable practice for men with learning disabilities (R)
	33	Men with learning disabilities should be permitted to have children within marriage
Non-Reproductive Sexual behaviour	3	Consenting men with a learning disability should be allowed to live in a homosexual relationship if they so desire
	9	Masturbation should be discouraged for men with a learning disability (R)
	12	Masturbation in private for men with a learning disability is an acceptable form of sexual expression
	23	It is a good idea to ensure privacy at home for men with a learning disability who wish to masturbate
	31	Masturbation should be taught to men with a learning disability as an acceptable form of sexual expression in sex education courses
Self-Control		
	8	Medication should be used as a means of inhibiting sexual desire in men with a learning disability (R)
	27	Men with a learning disability are more easily stimulated sexually than people without a learning disability (R)
	34	Men with a learning disability have stronger sexual feelings than other men (R)

Notes:

1. *28 items are shown with the original numbering system from 34 item scale (Cuskelley & Gilmore (2007)*
2. *R = reverse scored items.*

2.4.3: Attitudes towards the sexuality of people with learning disabilities - a brief qualitative measure

Due to the limited research within this area, particularly with assessing the differences in attitudes between ethnic groups, an open ended question was also used to collect additional qualitative data that may have not been captured by the ASQ-ID. This question asked the participant whether they had any more comments they would like to make about the sexuality of either males or females (dependent on which version of the ASQ-ID was used) with a learning disability.

2.4.4: Measure of recognition of a mild learning disability

The use of a vignette was developed by Scior and Furnham (2011) as a method of assessing recognition of a mild learning disability in lay people. Following presentation of the vignette, respondents are encouraged to label the symptoms depicted by being asked "what, if anything, do you think is wrong with X?" Their responses are then used to assess recognition. Following the recognition question, the vignette is also used to orientate respondents to a series of further questions about their views on learning disabilities.

This vignette method of assessing recognition of a learning disability was employed in this study. Two vignettes (one male and one female) were developed for use in the study and were modified versions of the learning disability vignette developed by Scior & Furnham (2011). These are depicted in figure 3 and 4 below. The original version used by Scior & Furham (2011) can be found in appendix four (p.154). Modifications that were made included using names that would familiar to both White

and South Asian cultures and also describing impairments in adaptive functioning in a more gender neutral manner.

Figure 3

Male questionnaire version vignette- the case of Dylan

Dylan is 22 and lives at home with his parents and younger brother. He found school a struggle and left without any qualifications. He has had occasional casual jobs since. When his parents try to encourage him to make plans for his future, Dylan has few ideas or expresses ambitions that are well out of his reach. Rather than having him at home doing nothing his parents have been trying to teach Dylan new skills, so he can help with some tasks in the family business, but he has struggled to follow their instructions. He opened up a bank account with his parents' help, but has little idea of budgeting and, unless his parents stop him, Dylan will spend all his benefits on comics and DVDs as soon as he receives his money.

Figure 4

Female questionnaire version vignette- the case of Sonia

Sonia is 22 and lives at home with her parents and younger brother. She found school a struggle and left without any qualifications. She has had occasional casual jobs since. When her parents try to encourage her to make plans for her future, Sonia has few ideas or expresses ambitions that are well out of her reach. Rather than having her at home doing nothing her parents have been trying to teach Sonia new skills, so she can help with some tasks in the family business, but she has struggled to follow their instructions. She opened up a bank account with her parents' help, but has little idea of budgeting and, unless her parents stop her, Sonia will spend all her benefits on comics and DVDs as soon as she receives her money.

Following the presentation of one of these vignettes, participants were encouraged to label the symptoms being depicted by being asked 'what, if anything, do you think is wrong with X?' This was the measure of recognition. For the purposes of quantitative analysis, responses were categorised by two raters as either 'recognised' or 'not recognised' and inter-rater reliability was also assessed via the Kappa statistic.

2.4.5: Measure of prior contact with people with learning disabilities

To asses prior contact the participant was asked about whether they had ever met someone with a learning disability and if so in what capacity. Again, for the purposes of quantitative analysis, responses were categorised by two raters as either “yes” or ‘”no” and inter-rater reliability was also assessed. For a more qualitative consideration, these responses were also categorised.

2.5: Procedure

2.5.1: Piloting

Following ethical approval and calculation of estimated sample sizes required, two online questionnaires were designed using the Royal Holloway Psychology Departments survey software (Select Survey ASP Advanced v8.6.4). Both questionnaires were of the same format and design but one contained the female vignette and female sexuality questions and the other the corresponding male versions. Each questionnaire consisted of six parts including socio-demographic information, the ASQ-GP (either male or female), the vignette (either male or female), the recognition question, information about learning disabilities, the previous contact questions and lastly the ASQ-ID (either male or female). The online questionnaires were piloted with four members of the public including two trainee clinical psychologist and two people from non-psychology backgrounds. Table 1 summarises the feedback received and action undertaken during this piloting phase.

Table 1: *Notes detailing feedback and action undertaken during the piloting phase*

Feedback	Action taken
Typos/ grammatical errors/ formatting	*All such errors were corrected*
Comments about the information page being too wordy and not referencing that the questions only ask about one gender	*The information page was shortened and included a brief statement about whether the questionnaire was asking about male or female sexuality*
Comments about the language/wording/format of questions: i) need for consistency in wording of men / young men/ boys. ii) a suggestion to split questions to pre and post adulthood, iii) need to simplify language e.g. omit words such as "can rear" iv) recommendations reduce number of questions and to use shorter questions.	*The authors of the ASQ-GP and ASQ-ID were contacted to request permission whether the language referring to males/females could be made more consistent. However, as there was no response from this request, it was assumed that permission was not granted so this adjustment was not made. However, this feedback was accommodated to some degree as before the start of the ASQ-ID participants were reminded that the questions were asking about "female sexuality- both girls and women" or "male sexuality - both boys and men." The 6 additional questions that were not part of any of the subscales of the ASQ-ID yet provided by the authors were omitted, with permission. Omitting any more questions was not possible as this would have invalidated the scales.*
A recommendation to include questions about whether the person was born in the UK whether they have children	*Although not used to test specific hypotheses for this study this recommendation was included in the questionnaires for exploratory analyses and to inform the description of participants. This included a question about whether the participant has children and whether the participant was born in the UK. If participants responded that they were not born in the UK, they were asked to respond to another following question which asked them to state how long they had been living in the UK.*
A recommendation to simply definition of learning disability and to make it less technical	*The definition was simplified following further advice from a clinical psychologist that specialised in the area of learning disabilities.*

2.5.2: Online Questionnaires

An example of the male version of the questionnaire used can be found in appendix 2 (p.141-152). After participants had the opportunity to read the information sheet and provide informed consent, they were asked to complete the following:

1. Socio-demographic information - participants were asked about their socio-demographic details including their age, gender, and ethnicity, whether they had children, whether they were born in the UK and if not their length of residency in the UK, their education level, religion and profession.

2. ASQ-GP

3. Vignette: This was introduced by stating the section was interested in whether people could recognise symptoms of a particular problem. One of two vignettes was presented to participants (either male or female corresponding to the appropriate gender version of the ASQ-GP and ASQ-ID administered). The rationale for using the same gender vignette was to provide some continuity to the questions being asked throughout the questionnaire and to also orientate participants to the appropriate gender referred to in the ASQ-ID. This was then followed by the recognition question: What do you think, if anything, is wrong with Dylan/Sonia?

4. Brief information about learning disabilities was then presented before questions about prior contact were asked. This information was derived from a range of sources including the BPS (2001) and Mencap (2014). Figure 5 depicts this information that was presented.

5. The ASQ-ID was the last measure to be presented followed by a question that asked if participants had any other comments regarding the sexuality of males (or females) with learning disabilities

6. In the final two pages, participation were asked to provide their email address if they wanted to be entered into the prize draw, were thanked for their participation and reminded of the researchers' email addresses should they have any further questions.

Figure 5

Information/definition of learning disability that was presented to participants

[Name of person in the vignette] is a person with a mild learning disability. People with learning disabilities are also sometimes referred to as 'mentally handicapped.' The term 'intellectual disability' is also used.

Having a learning disability affects the way a person understands information and how they communicate. This means they also have difficulties with daily living such as:

- *Looking after themselves, getting dressed, going to the bathroom, preparing food*
- *Social skills with peers, family members, adults and others*
- *Attending mainstream schools (they may have attended a special school or needed extra help at school*

2.5.3: Recruitment

The majority of participants were recruited in response to adverts on social networking sites including Facebook, LinkedIn Twitter, online classified advert websites including Gumtree, Preloved, Friday Adds and numerous internet forums. Six South Asian participants completed paper copies and were recruited from a town centre that was local to the researcher. The vast majority of participants were therefore recruited via online opportunity sampling. This was via two advertisements, each containing one link

to one of the versions of the questionnaires. Adverts with a link to each gender version were distributed evenly as possible to ensure target numbers where achieved and there was equal representation of participant characteristics within each group. A sample of one of the online messages/adverts can be found in appendix 3 (p.153).

Due to there being a slower rate of recruitment of South Asian participants the following strategies were employed:

- South Asian community groups were contacted requesting participation; however this did not yield any responses.

- Adverts were regularly posted on a number South Asian online groups on Facebook

- The researcher's personal social networks that were from South Asian communities were contacted and reminded to complete the questionnaire.

2.5.4; Data Collation & Analysis

Data was retrieved from the survey software onto Microsoft Excel spreadsheets. These documents were reorganised and collated and transferred onto a data set within a statistical software package (IBM SPSS Statistics 21). The main analyses involved identifying potential covariates and conducting parametric Analyses of Variance (ANOVA) and Analysis of Covariance (ANCOVA). The brief qualitative data that was collected was analysed using Thematic Analysis procedures (Braun & Clark, 2006).

CHAPTER 3

RESULTS

3.1: Introduction

This chapter reports upon the data screening procedures, descriptive statistics and the statistical testing of each of the five hypotheses. In order to test each of the hypotheses a multivariate analysis of variance (MANOVA) was initially considered. However this was not proceeded with due to the sensitivity of this test to outliers and unequal group sizes as was evident in the recruited sample.

Hypotheses were assessed via ANOVA's and ANCOVA's. This employed approach of individual univariate testing was also justified as it allowed a hypothesis driven factor analyses, as per the aims of the present study. Post-hoc analyses with individual fisher protected t-tests were then undertaken to assess for the direction of the hypothesised effects of interest. In order to guard against committing a Type 1 error a Bonferroni correction was applied for the required significance level ($P < 0.005$) for these t-tests. For many of these t-tests, the assumptions of homogeneity of variance were violated (as assessed by Levene's F value, $p < 0.05$) and separate variance estimates were used.

All the analyses for hypotheses testing were firstly undertaken with the identified outliers included and these results are reported in full in this chapter. The analyses were repeated with the outliers removed and any changes to interpretation as a result of these analyses have been reported.

3.2: Data Screening

3.2.1: Overview of data screening procedures

The data were initially examined for reliability and missing values. This was followed by testing of the data for normal distributions as this is an assumption required for the use of parametric tests that were employed for the testing of the hypotheses.

3.2.2: Reliability Assessments

Inter-rater Reliability

Inter-rater consistency was assessed for the rating of the recognition measure (whether learning disability was recognised or not recognised from the vignette). Data rated by two raters on a random selection of 10% of the sample (N = 31) demonstrated that the inter-rater agreement (Cohen's Kappa) for the two raters was kappa = 1.0, indicating full level of agreement between the raters. Therefore, a high level of reliability in ratings for the recognition measure for the rest of the data values was also assumed.

Internal Consistency Reliability

Internal consistency was assessed using Cronbach's alphas for the items on both the male and female versions of the ASQ-GP and ASQ-ID scales (Cronbach, 1951). Missing data were excluded in this assessment for internal consistency due to default list-wise deletion of missing data in SPSS. List-wise deletion was justified for these analyses because imputed values for missing data tend to inflate reliability estimates (Downey & King, 1998). Responses within the fully completed scales were found to range from acceptable to high levels of reliability in their internal consistency as has

been summarised in table 2. All scales except the Self-Control scale showed only marginal changes in the alpha values with the removal of particular items.

Table 2

Summary of reliability analyses of attitudes towards sexuality scales

Scale	Number of Items	α	South Asian N	White Western N	Total N
ASQ-GP:					
Sexual Openness	7	0.74	146	180	326
ASQ-ID:					
Sexual Rights	13	0.84	144	183	327
Parenting	7	0.86	138	182	320
Non-Rep. Sexual Beh.	5	0.78	141	182	323
Self-control	3	0.73	134	179	313

3.2.3 Missing Values

Mean scores from the items within each of the five sexual attitudes scales were used to produce values for the scale scores. This included the one scale derived from the ASQ-GP called ‘Sexual Openness’ which measured attitudes towards the sexuality of males and females in the general population. The other four scales were derived from the ASQ-ID, which measured specific aspects of sexual attitudes towards people with learning disabilities (Sexual Rights, Non-Reproductive Sexual Behaviour, Parenting and Sexual Rights).

Person-mean imputation with a minimum item threshold (80%) for each of the five scales was used to compensate for missing items values within these scale items (Bono, Ried, Kimberlin & Vogel, 1997; Downey & King, 1998). Therefore, the mean of the available items were computed to produce values for the scales providing that at least 80% items within each scale were completed. Missing data for the Self-Control scale was not handled in this way, as there were only three items and also because the reliability analysis demonstrated large reductions in alpha if any items were removed. Therefore any missing data on the items for the Self-Control scale resulted in list-wise deletion.

Missing data that did not meet these thresholds were found to occur more frequently in the South Asian sample (10.9%) in comparison to the White Western sample (5.4%). This resulted in a list-wise deletion of only one case.

3.2.4: Assessing for Normal Distributions

The normality of the distribution of the data on the key interval variables of the study were assessed visually via plotting of histograms. This was undertaken for each of the four sets of data depending on the independent variables of Ethnicity and Questionnaire Version. A visual analysis of these histograms suggested that the distributions of scores on all the scales were all normally distributed within each of the four groups of data.

Skew and kurtosis were then tested for all variables within each group and distributions were considered normal if the Z score was less than 2.58 (P>0.01). Skewness and Kurtosis Z scores were found to be non-significant ($p > 0.01$) on all five scales within each of the four groups.

Therefore it was concluded that the assumptions of normally distributed data had not been violated and parametric statistical tests for assessing the hypotheses were appropriate analyses to employ.

3.2.5: Outlier Analyses

Box plots were computed to assess the presence of outliers which were defined as a score of more than three standard deviations from the mean. A total of 15 univariate outliers were identified in the data, as assessed by inspection of a boxplot for values greater than 1.5 box-lengths from the edge of the box. These univariate outliers included four values from the Sexual Openness Scale, two from the Sexual Rights Scale, four from the Parenting Scale, three from the Non-reproductive Sexual Behaviour scale and two from the Self-Control Subscale. These outlier values were from eleven participants, ten of whom were from White Western backgrounds. No other explanation was able to be determined as to why the scores of the identified outliers deviated more than three standard deviations from the mean.

Due to the large sample size, it was assumed that these outliers were extreme values that were part of the normal distribution as no skew or kurtosis of the distribution was identified in each of the groups. Therefore, data used in the main analyses was firstly analysed with these outliers included. The analyses were then repeated with the outliers removed to assess for consistency. Most of the significance levels tested for did not change when outliers were removed from the data set. On two occasions, significance was achieved with removal of outliers and these have been reported within the main findings section.

3.3: Descriptive Statistics

Descriptive analyses were undertaken in order to obtain an understanding of the sample demographics, including the representation of two ethnic groups. Data within each questionnaire version and within each ethnic group was also assessed for differences for potential confounding factors including demographics, recognition and prior contact.

3.3.1: Sample Sizes and Demographic Characteristics

Overall Sample

The total sample of the present study consisted of 331 people that confirmed to be aged over 18 and residing within the UK. 172 participants completed the male version of the questionnaire (52%) and 159 completed the female version (48%). Within the total sample, 184 participants confirmed that they were White Western (55.6%) and 147 indicated that they were from a South Asian ethnic group (44.4%). Table 3 below depicts the number of participants that completed each questionnaire version within each ethnic group.

Table 3

N values and percentages within each questionnaire version and ethnic group

Questionnaire Version	South Asian	White Western
Male	74 (22.4%)	98 (29.6%)
Female	73 (22.1%)	86 (26.0%)

Ethnicity

Most of the sample described their ethnicity as either White British (48.6%) or of Indian origin (36.9%). Table 4 summarises the ethnic groups that participated in the study.

Table 4

Total sample (N = 331) broken down by ethnic group

Ethnicity	%
White British	48.6
White Irish	2.7
Other White	4.2
Indian	36.9
Pakistani	4.2
Bangladeshi	3.0
Sri Lankan	0.3

Religion

As we would expect to be associated with the ethnic groups recruited, the majority of the sample described their religion as being either Christianity (23%) or Hinduism (29.6%), although just over a third stated having no religion (32.3%). Table 5 below summarises the proportions of the sample from different faiths.

Table 5

Total sample (N = 331) broken down by stated religion

Religion	Total Sample %
None	32.3
Hinduism	29.6
Judaism	0.6
Christianity	23
Islam	8.5
Jainism	0.3
Sikhism	3.6
Buddhism	0.6
Total response	98.5
Unknown (missing)	1.5

Gender

Within the whole sample there was almost an equal representation of both female (52%) and male (46.5%) participants. This near equal balance of the gender of participants was also obtained within the South Asian and White ethnic groups, as is shown in table 6 below.

Table 6

Percentages representations for gender of the total (n = 331), South Asian (n = 147) and White Western (n = 184) samples.

		Total %	White Western %	South Asian %
Gender	Male	46.5	43.5	50.3
	Female	52	56	46.9
	Total response	98.5	99.5	97.3
	Unknown (missing)	1.5	0.5	2.7

Relationship Status, Education and Occupation

Most participants that completed the study stated that they were either single (35%) or married (43.5%). As with previous research using online methodology, the study recruited a highly educated sample as most participants had a level of education to at least undergraduate degree level (39.9%) or postgraduate degree level (35.3%). Almost two thirds of the participants confirmed that they were employed in professions that were *not* part of the education, health or social care sectors (62.8%). This suggested that the total sample was fairly representative of the "lay population" that may not have professional knowledge of learning disabilities. However, the total sample was not representative of educational levels as most were highly educated that had completed either an undergraduate (39.9%) or post-graduate degree (35.3%). Tables 7 and 8 on the following pages provide full details for the demographics of relationship status, education and occupation.

Table 7

Percentage representations showing the demographics of education level and occupational status within total (N = 331), South Asian (n = 147) and White Western (n = 184) samples.

		Total %	White Western %	South Asian %
Education	No qualifications	0.9	0.5	1.4
	GCSE	6.9	8.2	5.4
	A-level	16.3	19	12.9
	Undergraduate	39.9	40.8	38.8
	Postgraduate	35.3	31.5	40.1
	Total response	99.4	100.0	98.6
	Unknown (missing)	0.6	0.0	1.4
Occupation	Health/Social	13	13.0	12.9
	Education	5.1	6.0	4.1
	Homemaker	2.7	3.8	1.4
	Student	5.1	2.7	8.2
	Other Employment	62.8	66.3	58.5
	Retired	1.2	2.2	0
	Unemployed	2.4	1.6	3.4
	Total response	92.4	95.7	88.4
	Unknown (missing)	7.6	4.3	11.6

Table 8

Percentage representations of relationship status responses of the total (N = 331), South Asian (n = 147) and White Western (n = 184) samples.

		Total %	White Western %	South Asian %
Relationship Status	Single	35	31	40.1
	Married	43.5	37.5	51
	Civil Part.	1.2	1.6	0.7
	Cohabiting	15.7	25	4.1
	Separated	0.3	0	0.7
	Divorced	3.6	4.3	2.7
	Widowed	0.6	0.5	0.7
	Total response	100	100	100

Age and Children

Almost half the participants had answered ‘yes’ to the question about whether they had children (44.1%) and almost a third did not respond to this question (27.8%). The relatively high percentage of participants that had children (in addition to the non-responders that may also have children) was perhaps expected given the age range of the sample. The majority of participants were either in their late twenties (29%) or early thirties (30.5%). Tables 9 and 10 on the following two pages provide full details of these demographics.

Table 9

Percentage representations of age within the total (N = 331), South Asian (n = 184) and White Western (n = 184) samples.

		White Western %	South Asian %
Age	18-24	6.5	11.6
	25-29	26.1	32.7
	30-34	32.6	27.9
	35-39	10.9	9.5
	40-44	9.8	6.8
	45-49	6	4.1
	50-54	3.8	2.7
	55-59	1.6	3.4
	60-64	2.2	0.7
	65-69	0.5	0
	Total response	100.0	99.3
	Unknown (missing)	0.0	0.7

Table 10

Percentage representations of responses to question about children within the total (N = 331), South Asian (n = 147) and White Western (n = 184) samples.

		Total Sample %	White Western %	South Asian %
Children	No	28.1	26.6	29.9
	Yes	44.1	48.4	38.8
	Total response	72.2	75	68.7
	Unknown (missing)	27.8	25	31.3

UK Residency

Most participants stated that they were either born in the UK (74.9%) or had lived in the UK for at least 8 years (14.5%). As would be expected, there was a higher proportion of White Westerns (84.2%) that were British born in comparison to the South Asian sample (63.3%). Table 11 below provides an overview of this data.

Table 11

Percentage representations of UK length of residency within the total (N = 331), South Asian (n = 147) and White Western (n = 184) samples.

UK Residency Status	Total Sample %	White Western %	South Asian %
British Born	74.9	84.2	63.3
< 1 year	1.8	1.6	2.0
1-3 years	2.1	0.00	4.8
4-7 years	3.0	2.2	4.1
8+ years	14.5	9.8	20.4
Total	96.4	97.8	94.6
Unknown (Missing)	3.6	2.2	5.4

3.4: Recognition of a Learning Disability and Previous Contact

3.4.1: Recognition

Nearly all participants (98%) provided an answer to the recognition question that was presented after the vignette. Based on the participants that answered this question, recognition of a mild learning disability was generally low. Only about one fifth of this sample (20.8%) correctly identified that the vignette was describing a person with a learning disability. Within this sample of participants that recognised the learning disability, White Westerners showed higher levels of recognition (69.6%) compared to South Asians (30.4%) and this difference was found to be statistically significant [$\chi^2(1) = 6.85$, $p < 0.05$].

Table 12 below summarises categories of responses for the recognition question between the two ethnic groups. As is evident from this table, the category with the highest frequency shows that nearly one fifth of the sample attributed the difficulties presented as being due to poor support from parenting and education services in both ethnic groups.

Table 12

Percentage representations of recognition within the total (N = 331), South Asian (n = 147) and White Western (n = 184) samples.

	Total Sample %	White Western %	South Asian %
Related Conditions	8.5	10.3	6.1
Depression	4.2	5.4	2.7
Other Mental Illness	1.2	0.5	2
Poor parenting/support	19.3	17.9	21.1
Lazy/Selfish/ Low motivation	7.6	3.8	12.2
Low self-esteem/confidence	5.4	4.9	6.1
Immature	4.5	3.3	6.1
Other Mental Illness	10	10.3	9.5
Don’t know/ Missing	8.8	9.8	7.5
Nothing	9.7	7.6	12.2
Learning Disability (recognised)	20.8	26.1	14.3

3.4.2: Prior Contact

After participants were told that the person in the vignette had a learning disability and they were provided with a definition of a learning disability, most participants stated that they had been in prior contact with a person with a learning disability (72.8%) mostly via family (22.7%), friends (21.1%) or work colleagues (21.8%). This suggested that whilst recognising and labelling a learning disability via a vignette account was poor, most participants have come into contact with a person with these difficulties. However, it appeared that many participants attributed prior contact with a person with related conditions (e.g. Autistic Spectrum Disorders and specific difficulties such as Dyslexia) and this may explain the higher scored rate of prior contact despite the low levels of recognition. This discrepancy is explored further in the discussion chapter, but suggests that the measure of prior contact in this study is not valid for people who may comprehend the term 'learning disabilities' incorrectly.

3.5: Overview of ASQ-ID & ASQ-GP scores

Overall, participants demonstrated generally positive attitudes towards the sexuality of men and women with learning disabilities. This was indicated by the total mean response to all the ASQ-ID items for both the White Western (M = 5.02, SD = 0.58) and South Asian participants (M = 4.51 SD = 0.76). This was also consistent with attitudes towards sexuality in typically developing men and women as was evident from the mean response on the ASQ-GP in White Westerns (M = 5.33, SD = 0.61) and South Asians participants (M = 4.70, SD = 0.82). Further details on sample sizes, mean and standard deviations for each of the five sexual attitude scales can be found in tables 13-17 (p. 83-94).

3.6: Main findings: Hypotheses Testing

3.6.1: Identification of covariates

In order to control for known confounding factors during hypotheses testing, the total sample was firstly organised into four data sets depending on which questionnaire version was completed (male or female) and whether participants were White Western or South Asian (see table 3 p.70). These four data sets were assessed for differences between each other via a number of Chi-squared tests of associations. This was undertaken for the variables identified from previous research that have also been found to also influence attitudes towards sexuality in the general population and the sexuality in people with learning disabilities. These included the variables of age, gender, education, occupational status, religion, length of residency (acculturation), recognition of a mild learning disability and previous contact with a person with a learning disability.

Pearson's Chi-Squared tests indicated the following variables were not equally distributed between the data from the two questionnaire version and/or the two ethnic groups: Education [$\chi^2(12) = 22.50$, $p = 0.037$], Occupation [$\chi^2(18) = 37.07$, $p = 0.005$] and Recognition [$\chi^2(3) = 16.07$ $p = 0.001$]. These were therefore included as covariates when testing the main hypotheses.

No significance differences were found for the following variables: Gender [$\chi^2(5.08)= 5.08$, $p = 0.160$], Age [$\chi^2(27) = 27.15$, $p = 0.464$] and previous contact [$\chi^2(3) = 5.68$, $p = 0.128$]. The effect of having children, although not confirmed by previous research, was also proposed to be a potential covariate influencing attitudes towards sexuality, particularly with regards to parenting rights. However, no difference was also found

between the samples in whether participants had children [$\chi^2(3) = 1.618$, $p = 0.655$]. Additionally, no significant differences were found within the South Asian samples between the two questionnaire versions on religion [$\chi^2(6) = 11.164$, $p = 0.083$] and length of UK residency [$\chi^2(4) = 2.452$, $p = 0.653$]. Within the White Western sample, there was also no significant differences in religion between the two questionnaire versions [$\chi^2(4) = 7.18$, $p = 0.127$].

3.6.2: Hypothesis 1

British South Asians will have more negative attitudes towards the sexuality of both men and women in the typically developing population (less sexual openness) than British White Westerners.

In order to test hypotheses 1, an independent ANOVA was firstly employed to compare the effect of ethnicity (White Western/South Asian) on sexual openness attitudes scores within each of the questionnaire versions (male sexuality/female sexuality). A significant small effect of ethnicity was found, indicating a difference in sexual openness attitudes between White Westerners and South Asian participants [$F(1, 322) = 64.87$, $p < 0.001$, $\eta^2 = 0.168$]. There was no main effect of questionnaire version [$F(1, 322) = 1.24$, $p = 0.266$, $\eta^2 = 0.004$], indicating that sexual openness attitudes towards typically developing men and women did not differ significantly. The interaction of ethnicity and questionnaire version was not significant [$F(1,322) = 3.07$, $p = 0.08$, $\eta^2 = 0.009$]. Means and standard deviations of the sexual openness scores obtained from both ethnic groups and questionnaire versions are displayed in table 13 below.

Table 13

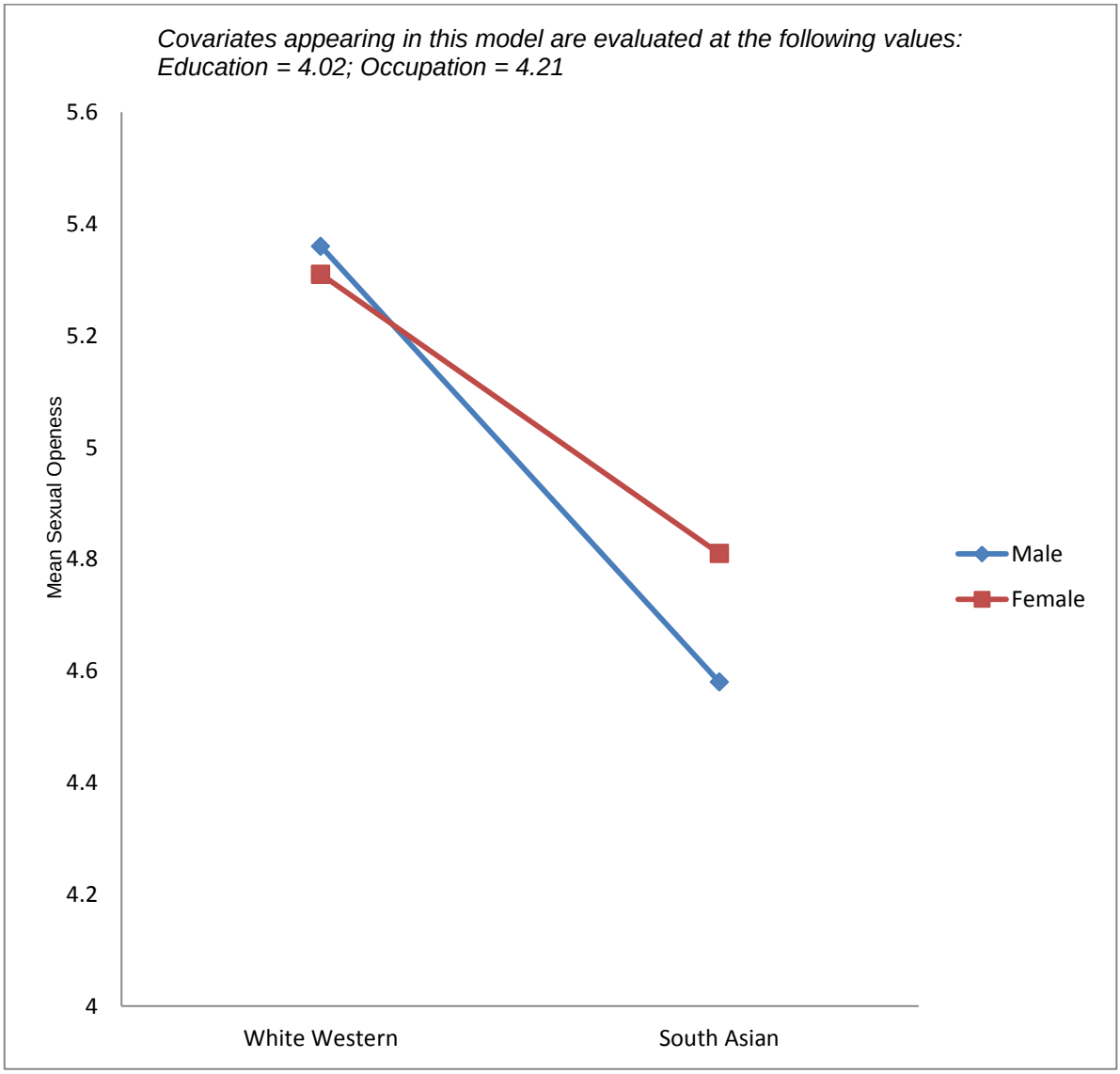
Sexual Openness Scores: Mean, Standard Deviation and N values

Ethnicity	Questionnaire Version	M	SD	N
White Western	Male	5.36	0.54	95
	Female	5.31	0.67	85
	Total	5.33	0.61	180
South Asian	Male	4.58	0.78	74
	Female	4.81	0.84	72
	Total	4.70	0.82	146
Total	Male	5.02	0.76	169
	Female	5.08	0.79	157
	Total	5.05	0.78	326

In order to assess whether these significant main effects on sexual openness scores were maintained when the covariates of education and occupation were accounted for, an independent ANCOVA was employed. In this model, the effect of Ethnicity remained significant [$F(1,294) = 57.52$, $p < 0.001$, $\eta^2 = 0.164$]. The effect of questionnaire version remained non-significant [$F(1,294) = 1.78$, $p = 0.182$, $\eta^2 = 0.006$] . However the ANCOVA procedure led to the very small interaction effect reaching significance [$F(1, 294) = 4.39$, $p = 0.037$, $\eta^2 = 0.015$] indicating that sexual openness scores was dependent on the interaction of the two factors of ethnicity and questionnaire version. In order to interpret this interaction figure six was computed.

Figure 6

Plot depicting interaction between ethnicity and questionnaire version on mean Sexual Openness scores



As can be observed visually from figure 6, there appears to be a difference in attitudes towards sexual openness of men and women only within the South Asian sample. The significant interaction suggests that within the South Asian sample only, attitudes towards sexual openness of typically developing women are more positive than typically developing men.

Post-hoc Fisher protected post-hoc t-tests with a Bonferroni correction ($p < 0.005$) supported hypothesis 1, where British South Asians showed significantly lower scores compared to White Westerners on sexual openness towards the sexuality of typically developing men [$t(167) = -7.58$, $p < 0.001$] and women [$t(155) = -4.52$, $p < 0.001$].

In conclusion, hypothesis 1 was fully supported. South Asian participants were found to have significantly more negative attitudes towards the sexuality of both typically developing men and women compared to White Westerners. This was independent of the effects of two demographic variables that are known to also influence sexual attitudes that were found to be unequally distributed between the two ethnic groups (education and occupation). Furthermore, the interaction that reached significance when these covariates were added indicated that difference in attitudes between the sexuality of males and females in the typically developing population was dependent on ethnic group. Specifically, unlike the White Western group, the South Asian group were more positive in their attitudes towards the sexuality of women compared to men in the typically developing population.

3.6.3: Hypothesis 2

British South Asians will have more negative attitudes towards sexual rights of both men and women with learning disabilities compared to British White Westerners.

In order to test hypotheses 2, an independent ANOVA was employed to compare the effect of ethnicity (White Western/South Asian) on attitudes towards sexual rights of men and women with learning disabilities (male/female questionnaire version). There was a main effect of ethnicity, indicating a difference in attitudes towards the sexual rights of people with learning disabilities between White Westerners and South Asian

participants [F(1,323) = 52.18, p < 0.001, η^2 = 0.139]. There was also a main effect of questionnaire version [F(1, 323) = 5.74, p = 0.017, η^2 = 0.017], indicating that attitudes towards sexual rights of men and women with learning disabilities differed significantly. There was no significant interaction between ethnicity and questionnaire version [F(1,323) = 1.54, p = 0.215, η^2 = 0.005] indicating that attitudes towards sexual rights of men and women with learning disabilities were not dependent on whether participants were White Western or South Asian. Means and standard deviations of the Sexual Rights scores obtained from both ethnic groups and questionnaire versions are displayed in table 14 below.

In order to assess whether these significant main effects on the sexual rights scores were maintained when the covariates of sexual openness in the typically developing population, education, occupation and recognition were accounted for, an independent ANCOVA was employed. The effect of Ethnicity remained significant [F(1,288) = 13.34, p < 0.001, η^2 = 0.044]. The effect of questionnaire version however, was no longer significant [F(1,293) = 3.70, p = 0.055, η^2 = 0.013], indicating that the differences in mean scores between the two questionnaire versions was due to differences in the one or more of the covariates added to the model. The interaction between ethnicity and questionnaire version remained non-significant [F(1,323) = 1.29, p = 0.257, η^2 = 0.004].

Table 14

Sexual Rights Scores: Mean, Standard Deviation and N values

Ethnicity	Questionnaire Version	M	SD	N
White Western	Male	4.94	0.60	98
	Female	5.02	0.57	85
	Total	4.98	0.59	183
South Asian	Male	4.31	0.79	72
	Female	4.58	0.70	72
	Total	4.45	0.75	144
Total	Male	4.67	0.75	170
	Female	4.82	0.67	157
	Total	4.74	0.72	327

Post-hoc Fisher protected t-tests with a Bonferroni correction ($p < 0.005$) supported hypothesis 2, where British South Asians showed significantly lower scores on attitudes towards sexual rights of both men [$t(168) = -5.87$, $p < 0.001$] and women [$t(155) = -4.35$, $p < 0.001$] with learning disabilities.

Therefore these results concluded that hypothesis 2 was fully supported as South Asian participants were found to have significantly more negative attitudes towards the sexual rights of both men and women with a learning disability compared to White Westerners. This difference in the hypothesised direction remained even after

controlling for covariates of sexual openness in the typically developing population, education, occupation and recognition.

3.6.4: Hypothesis 3

British South Asians will have more negative attitudes towards non-reproductive sexual behaviour of both men and women with learning disabilities compared to British White Westerners.

In order to test hypotheses 3, an independent ANOVA was employed to compare the effect of ethnicity (White Western/South Asian) on attitudes towards non-reproductive sexual behaviour of men and women with learning disabilities (male/female questionnaire version). There was a significant main effect of ethnicity, indicating a difference between South Asians and White Westerners in their attitudes towards non-reproductive sexual behaviour in people with learning disabilities [$F(1, 319) = 42.71$, $p < 0.001$, $\eta^2 = 0.118$]. There was no significant main effect of questionnaire version [$F(1, 319) = 0.01$, $p = 0.930$, $\eta^2 = 0.000$], indicating that there was no difference between attitudes towards non-reproductive sexual behaviour in men and women with learning disabilities. There was no significant interaction between ethnicity and questionnaire version [$F(1,319) = 1.54$, $p = 0.215$, $\eta^2 = 0.005$], indicating that attitudes towards non-reproductive sexual behaviour in men and women with learning disabilities was not dependent on whether participants were White Western or South Asian. Means and standard deviations of the Non-Reproductive Behaviour scores obtained from both ethnic groups and questionnaire versions are displayed in table 15 below.

Table 15

Non-Reproductive Sexual Behaviour Scores: Mean, Standard Deviation and N values

Ethnicity	Questionnaire Version	M	SD	N
White Western	Male	5.18	0.66	97.00
	Female	5.04	0.76	85.00
	Total	5.11	0.71	182.00
South Asian	Male	4.41	0.99	70.00
	Female	4.56	1.03	71.00
	Total	4.48	1.01	141.00
Total	Male	4.86	0.90	167.00
	Female	4.82	0.92	156.00
	Total	4.84	0.91	323.00

Post-hoc Fisher protected t-tests with a Bonferroni correction ($P < 0.005$) supported hypothesis three, where British South Asians showed significantly lower score on the non-reproductive sexual behaviour scale towards both males [$t(165) = -6.08$, $p < 0.001$] and females [$t(154) = -3.32$, $p = 0.002$] with a learning disability.

In order to assess whether these significant main effects on the non-reproductive sexual behaviour attitude scores were maintained when the covariates of sexual openness, education, occupation and recognition were accounted for, an independent ANCOVA was employed. The effect of Ethnicity in this model no longer reached significance [$F(1, 284) = 2.54$, $p = 0.112$, $\eta^2 = 0.009$]. This indicated that the difference

found between the two ethnic groups in their attitudes towards non-reproductive sexual behaviour in people with learning disabilities was due to the effect of one or more of the covariates added to the model. The effect of questionnaire version remained non-significant [F (1, 284) = 0.389, p = 0.534, η^2 = 0.001] as did the non-significant interaction between ethnicity and questionnaire version [F(1, 284) = 1.92, p = 0.167, η^2 = 0.007].

In conclusion hypothesis 3 was not supported. This is because whilst the results indicated a significant effect of ethnicity in the hypothesised direction, this appears to be a reflection of White Westerners being more liberal in their attitudes towards sexuality of men and women in the typically developing population and/or due to other factors known to influence attitudes towards sexuality in people with learning disabilities, namely education, occupation and the ability to recognise a learning disability.

3.6.5: Hypothesis 4

Compared to British White Westerners, British South Asians will have more positive attitudes towards parenting rights of men and women with learning disabilities.

In order to test hypotheses 4, an independent ANOVA was employed to compare the effect of ethnicity (White Western/South Asian) on attitudes towards parenting in people with learning disabilities on the two questionnaire versions (Male Sexuality/Female Sexuality). There was a significant main effect of ethnicity, indicating a difference in attitudes towards parenting in people with learning disabilities between White Westerners and South Asian participants [F(1, 3316) = 16.45, p < 0.001, η^2 = 0.049]. There was no significant main effect of questionnaire version [F(1, 316) = 1.90 ,

p = 0.169, η^2 = 0.006], indicating that attitudes towards parenting in men and women with learning disabilities did not differ. There was no significant interaction between ethnicity and questionnaire version [F(1,316) = 1.25, p = 0.265, η^2 = 0.004], indicating that attitudes towards parenting in males and females with a learning disability was not dependent on whether participants were White Western or South Asian. Means and standard deviations of the Non-Reproductive Behaviour scores obtained from both ethnic groups and questionnaire versions are displayed in table 16 below

Table 16

Parenting Attitude Scores: Mean, Standard Deviation and N values

Ethnicity	Questionnaire Version	M	SD	N
White Western	Male	5.08	0.76	93.00
	Female	5.09	0.83	80.00
	Total	5.08	0.79	173.00
South Asian	Male	4.55	0.96	59.00
	Female	4.85	0.90	61.00
	Total	4.70	0.94	120.00
Total	Male	4.87	0.88	152.00
	Female	4.99	0.87	141.00
	Total	4.93	0.87	293.00

In order to assess whether these significant main effects on the parenting scores were maintained when the covariates of sexual openness in the typically developing men and women, education, occupation and recognition were accounted for, an independent ANCOVA was employed. The effect of ethnicity in this model was no longer significant [F(1, 281) = 1.359, p = 0.245, η^2 = 0.005] although significance was achieved when the analysis was repeated with the removal of univariate outliers [F(1, 273) = 4.65, p = 0.032, η^2 = 0.017]. The effect of questionnaire version remained non-significant [F(1, 281) = 0.244 , p = 0.621 η^2 = 0.001] as did the non-significant interaction between ethnicity and questionnaire version [F(1, 281) = 1.012 , p = 0.315, η^2 = 0.004].

Post-hoc Fisher protected t-tests with a Bonferroni correction indicated that compared to White Westerners, South Asian participants showed significantly lower scores on attitudes towards parenting in men [t(163) = -3.71, p < 0.001] with learning disabilities Attitudes towards parenting in women with a learning disabilities were also more negative in South Asian participants compared to White Westerns, however this effect was only significant at the uncorrected alpha level [t(153) = -2.05, p = 0.042]. The significant effect towards males and trend in females were opposite and contrary to the hypothesised direction.

In conclusion, a hypothesis 4 was not supported and there was a trend in the opposite direction of hypothesised effect of ethnicity after controlling for covariates. Namely, South Asian participants appeared to have more negative attitudes towards parenting in both males and females with a learning disability, contrary to hypothesis 4. The statistical significance of this trend was inconclusive as significance was only achieved after removing univariate outliers for the ANCOVA analysis and at an uncorrected alpha level for the post-hoc analysis for the female questionnaire data.

3.6.6: Hypothesis 5

Both ethnic groups will view men with a learning disability as having less self-control of their sexuality than women with a learning disability

In order to test hypotheses 5, an independent ANOVA was employed to compare the effect of questionnaire version (male sexuality / female sexuality) on attitudes towards the self-control of sexuality in people with learning disabilities in both ethnic groups (White Western / South Asian). There was a significant main effect of questionnaire version [$F(1, 309) = 8.57$, $p = 0.004$, $\eta^2 = 0.027$], indicating that attitudes towards self-control of sexuality were significantly different towards men and women with learning disabilities There was a also a highly significant main effect of ethnicity [$F(1, 309) = 24.64$, $p < 0.001$, $\eta^2 = 0.074$], indicating that South Asian participants and White Westerners differed significantly in their attitudes towards self-control of sexuality in people with learning disabilities. There was no significant interaction between questionnaire version and ethnicity [$F(1,309) = 0.48$, $p = 0.487$, $\eta^2 = 0.002$], indicating that attitudes towards self-control of sexuality in men and women with a learning disabilities was not dependent on whether participants were White Western or South Asian.

Post-hoc Fisher protected t-tests with a Bonferroni correction found that attitudes towards the self-control of sexuality did not differ between males and females in both the South Asian [$t(132) = 2.05$, $p = 0.042$] and White Western [($t(177) = 2.00$, $p = 0.047$] ethnic groups. However, there was a trend of the effects in the hypothesised direction, as significance was reached at the uncorrected alpha level ($p < 0.05$). Means and standard deviations of the self-control scores obtained from both ethnic groups and questionnaire versions are displayed in the table 17 on the following page.

Table 17

Self-Control Attitude Scores: Mean, Standard Deviation and N values

Ethnicity	Questionnaire Version	M	SD	N
White Western	Male	4.83	0.77	93.00
	Female	4.24	1.10	56.00
	Total	4.61	0.95	149.00
South Asian	Male	5.12	0.75	77.00
	Female	4.67	0.97	61.00
	Total	4.92	0.88	138.00
Total	Male	4.96	0.77	170.00
	Female	4.46	1.05	117.00
	Total	4.76	0.93	287.00

In order to assess whether these significant main effects on the self-control scores were maintained when the covariates of attitudes towards sexual openness in the typically developing population, education, occupation and recognition were accounted for, an independent ANCOVA was employed. The effect of questionnaire version remained significant in this model [F(1, 275) = 6.87 , p = 0.009, η^2 = 0.24] . The effect of ethnicity also remained significant [F(1, 275) = 7.75, p = 0.006, η^2 = 0.027] as did the non-significant interaction between ethnicity and questionnaire version [F(1, 275) = 0.089, p = 0.766, η^2 = 0.000].

In conclusion, the observed trends of the effects of questionnaire version on the self-control scores for both ethnic groups are independent of the factors unequally distributed within the sample that are known to also influence sexual attitudes. In other words, the observed trend is not simply a reflection of differences in terms of other factors known to influence sexual attitudes namely education, occupation, the ability to recognise a learning disability and/or sexual openness attitudes towards people in the typically developing population. However, hypotheses 5 is only partially supported as the trends only reached significance at the uncorrected alpha level.

3.6.7: Summary of Main Findings

After controlling for potential covariates, South Asians participants were found to have significantly more negative attitudes towards sexuality of both men and women in the typically developing population and the sexual rights of men and women with learning disabilities compared to White Westerners (supporting hypothesis 1 and 2). Attitudes towards the non-reproductive sexual behaviour in both males and females with a learning disability were not found to differ between the two ethnic groups after controlling for identified covariates (not supporting hypotheses 3). Contrary to the prediction made, there was a trend for South Asian participants to show more negative attitudes towards the parenting rights of men and women with learning disabilities, even after controlling for identified covariates (not supporting hypotheses 4). Lastly, men with a learning disability were not viewed as having significantly less self-control of their sexuality than women with learning disabilities in either ethnic group, although there was a trend in this direction at an uncorrected alpha level (partially supporting hypothesis 5).

3.7: Qualitative Analysis

3.7.1: Themes Identified

A question that asked participants for ‘any other comments regarding the sexuality of males/females with a learning disability' provided the study additional brief qualitative data that supplemented the quantitative findings.

Within the South Asian sample, 36 out of 147 participants responded to the question. Within the White Western sample, 53 out of 184 participants provided a response. Thematic analysis identified four themes within the responses which appeared in both the White Western and South Asian samples in both questionnaire versions. Interestingly, none of the themes identified in the data explicitly referred to issues of ethnicity, culture or religion. The following four themes were identified:

1. Normalisation
2. Lack of knowledge about learning disabilities
3. Issues with generalisations
4. Concerns about children

The following section describes and provides quoted examples of responses from participants for each theme.

3.7.2: Theme 1 – Normalisation

A number of participant responses (*n* = 28) were indicative of strong views about equal rights for people with learning disabilities including their rights to a sexual life. This

themes emerged from both South Asian (*n* = 10) and White Western (*n* = 18) participants.

Data within the South Asian sample often referred to equal rights more generally rather than equality in sexuality; this is evident from the response from one South Asian participant below.

"They are still human beings and should be treated as such. Just because they have learning difficulties it does not mean that they are not normal. They may need more support and assistance from friends and family and should be allowed to perform normal activities as any male."

Other South Asian participants commented on the right for people with learning disabilities to lead a normal sexual life by referring to feelings and love:

"They might have slow learning ability, but they are no less in feelings. They have dreams too like everyone else and there is no shame if they live their feelings. Everyone has the right to make love and being loved."

A number of comments from White Westerners also expressed similar views:

"I believe it's the female's right to live as close to a normal life as possible regardless of learning disabilities"

"I have no knowledge of sexual desires of women with learning difficulties, however I do believe they have the right to sexual freedom"

"They should be treated equally, but with additional social support if necessary".

3.7.3: Theme 2- Lack of Knowledge about Learning Disabilities

A number of White Western participants admitted to their lack of knowledge or ignorance about learning disabilities and specifically suggested that there should have been a “don’t know” response in the questionnaire (*n = 10)*:

“To be honest I don't know enough about the experience of sexuality for females with learning disability, so perhaps this should be more common knowledge.”

“I am not in a position to answer many of the questions since I have no knowledge in the area in question.”

“I wish there had been an option to answer "I don't know" for some of the questions in this survey. For example, I honestly have no idea whether or not males with a learning disability are more or less interested in sex than males without a learning disability. I chose "mildly disagree" because my intuition tells me that a learning disability on its own (i.e. viewed separately to any associated stigma, marginalisation or differing experience of the world that might arise from having such a disability) wouldn't necessarily affect sexual desire, but this is not something I know to be the case.”

“Some questions I put an answer too where sometimes I'd have preferred a 'don't know' response”.

No responses were identified within the South Asian sample that were consistent with this theme concerned with admitting to lack of knowledge about sexuality in people with learning disabilities.

3.7.4: Theme 3- Issues with generalisation

Another major theme that emerged in the data were participants' views that sexuality in people with learning disabilities needs to be assessed on a case by case basis and that generalisations of about sexuality should not be made (*n = 11).* All but one of the responses corresponding this theme were from White Western participants (*n* = 10):

"You can't generalise about people with a learning disability in relation to their sexuality. There are too many variables. It would depend on their age, the level of their disability, their vulnerability, their culture. Some people like sex, some people would prefer a cup of tea, regardless of their intellect or cognition!"

"It is difficult to talk about 'women with learning disability' in general. Women and learning disabilities come in many forms. It depends on the women and the severity of the disability what my answer to the different questions would be."

"Large range within learning disabilities which would impact the man is different (less or more severe ways)."

3.7.5: Theme 4- Concerns about children

A few participants indicated that people with learning disabilities should be allowed to exercise sexual rights but showed concerns about child bearing and raising. These responses were only White Western participants (*n* = 5*):*

"I think any consenting adult with capacity has the right to take part in any sexual activity. However, females with a disability whom decide to have children, must receive adequate support to ensure those children are not at any risk. This is my biggest

concern when females with a learning disability have children, and the question is will the children be implicated by their mother's disability?"

"With sexual intercourse, marriage etc. I believe these are basic human rights, and there are no cases when these should be stopped. Having children is a different case however, as there is another human being to consider, i.e. the child. I think that discouragement entirely is not right, but I'd have concerns if there is no support for the parents who have learning disabilities. So I guess what I'm saying, is it's not that reproducing should be discouraged, it's more like, there is a necessity for on-going support and education to safeguard the children".

3.7.6: Qualitative Data: Summary and Conclusions

The qualitative obtained in the study indicated that most participants were pro-normalisation, although explicit references to sexuality was less frequently expressed in South Asian participants. Participants from both ethnic groups expressed concerns about people with learning disabilities becoming parents and were particularly thoughtful of issues surrounding the welfare of children if adequate parenting support was not available. Participants also expressed that generalisations should not be made about the sexuality in people with learning disabilities and that assessment should be on a case by case basis. Lastly, participants were found to admit to their lack of knowledge about learning disabilities. Some of these qualitative findings are considered further in the discussion chapter within the context of the main quantitative findings of the present study.

CHAPTER 4

DISCUSSION

4.1: Introduction

This chapter discusses the main findings from the study within the context of previous research and considers service implications. This is followed by a review of the strengths and limitations of the present study and suggested directions for future research.

4.2: Overview of Main Findings

The present study found relatively poor levels of recognition of a mild learning disability and there was a difference in recognition between the two ethnic groups. South Asian participants showed significantly lower rates of recognition than the White Western Participants. Identified factors that were known to influence attitudes towards sexuality of people with learning disabilities that were found to be unequally distributed within the sample were added as covariates in ANCOVA analyses. These included attitudes towards sexuality of men and women in the typically developing population, education, occupation and ability to recognise a learning disability.

South Asian participants were found to be significantly more negative in their attitudes towards the sexuality of men and women in the typically developing population compared to White Westerners (supporting hypothesis one). However, a significant interaction indicated that specifically, the South Asian participants were more negative

in these attitudes towards men compared to women. Compared to White Westerners, South Asian participants were also found to be significantly more negative in their attitudes towards the sexual rights of both men and women with learning disabilities, even after the effects of potential covariates were controlled for (supporting hypothesis two). No significant differences between the two ethnic groups were found in their attitudes towards non-reproductive sexual behaviour of men and women with a learning disability after controlling for potential covariates (not supporting hypothesis three). Trends in the data suggested that South Asian participants had more negative attitudes towards parenting rights of men and women with a learning disability after controlling for covariates and this was contrary to the hypothesised direction of difference (not supporting hypothesis four). Significance for these trends in the parenting scale was only achieved when univariate outliers were removed or when significance was considered at an uncorrected alpha level. Trends in the data that were significant at the uncorrected alpha level also suggested that both ethnic groups viewed men with learning disabilities as having less self-control of their sexuality than women with learning disabilities, after controlling for potential covariates (partially supporting hypothesis five).

4.3: Discussion of Main Findings

4.3.1: Recognition of a Learning Disability

This study found relatively poor levels of recognition of a mild learning disability in the lay population when provided with a validated vignette example. Only one fifth of the sample correctly labelled the vignette as a person having a learning disability. The qualitative data obtained in the study complemented these findings in that some participants were honest about their lack of knowledge about learning disabilities.

Recognition rates were found to be significantly lower in people from South Asian backgrounds compared to those that from White ethnicities.

The low recognition rates of mild learning disabilities that were found in this study are also consistent with the findings of previous studies. Scior et al. (2012) found recognition levels within an ethnically mixed example to be 27.8%, only slightly higher than the rate found in the present study (20.8%). Scior et al. (2012) also found that there to be a difference in recognition levels between different ethnic groups. Furthermore, in their qualitative study, Coles & Scior (2012) also documented how South Asian participants appeared to show higher levels of confusion and were much less likely to recall media representations of learning disabilities compared to White Westerners. The present study therefore offers further support to previous findings that South Asian communities in particular have lower levels of recognition and conceptualisation of a learning disability compared to White Westerners.

One clinical implication that arises from this is for services to continue to be mindful of poor recognition of a learning disability, particularly from South Asian communities. This study provides evidence for this to be the case for a mild learning disability. A fifth of the sample attributed a person's mild learning disability to poor parenting, education and social support. This suggests that services should also be aware of potential blame within the community not only towards the person with a learning disability, but also towards, parents, teachers and professionals.

The findings also suggest that a person's mild level of learning disability may not be recognised by families and carers and this may lead to reduced help seeking support from appropriate services. This may be a particular issue for people from South Asian communities, as they were found to be more likely to be unable to recognise a mild learning disability. This finding provides further supports to previous research which

has found there to be a lack of understand of learning disabilities and low uptake of services from South Asian families (Hatton et al., 1997; Chamba, et al., 199; Mir et al., 2001; Hatton et al, 2003; Sim & Bowes, 1998). Therefore, in order for clinicians to promote uptake of learning disability services, the present study further supports the need for projects promoting knowledge and awareness in the community, particular in areas where there are large South Asian populations.

4.3.2: Attitudes towards sexual openness in the typically developing population

A highly significant statistical difference was found between the two ethnic groups on the mean scale score of the ASQ-GP, which measured attitudes towards sexual openness towards men and women within the general population. This was even after controlling for the potential effects of education and occupation, the identified covariates that were found to be not equally represented within the groups. White Western participants scored significantly more highly on this measure than South Asian participants. This suggested that within the UK, South Asian participants had more negative attitudes towards sexuality in the typically population compared to White Westerners, a finding that supported the first hypothesis. This finding was also consistent with previous research that has suggested more conservative sexual attitudes in people from South Asian backgrounds (Griffiths et al., 2011; Davidson, 2000).

Considering that the majority of the South Asian participants that were recruited for the study were either born within the UK or had lived in the UK for a considerable period of time, one may expect these British South Asians to have acculturated to more liberal and Western sexual attitudes. Acculturation refers to the process in which people from minority ethnic groups incorporate and accommodate both aspects their culture of origin and that of the mainstream culture in which they reside (Ryder, Alden & Paulhus,

2000). The present study challenges this assumption and suggests that ethnic group or cultural differences in attitudes towards sexuality in general are still prevalent and are not influenced by whether one is British born or has lived in the UK for considerable period of time. Therefore we cannot assume the acculturation of liberal sexual attitudes in people from South Asian backgrounds. Previous studies also support this implication as acculturation has not been found to account for all ethnic group differences in sexual attitudes, suggesting that some of these attitudes are not subject to change during a cultural integration process (Athrold & Meston, 2010).

This has implications in professional practice when working with people from South Asian backgrounds. Professionals may need to be aware of the level of conservatism towards sex in South Asian families in addition to being cautious and sensitive when exploring sexual issues. This appears may be challenging and present itself with ethical and professional dilemmas. For example, unanticipated disputes between service-users, families and professionals may occur due to differences in beliefs surrounding sexual issues such as sex outside marriage, age of first sexual intercourse, appropriateness of particular sexual behaviours and the acceptance of homosexuality. Barriers may also exist in facilitating open discussion of sexuality due to shame and embarrassment. Role models of managing these issues from professionals that are from the South Asian ethnic groups themselves may provide a better insight into how best to manage these challenges. Therefore the present study's findings support the need for services to employ cultural advisors in order to deliver culturally sensitive services.

The significant interaction indicated that within the South Asian population only, there was more of a discrepancy between attitudes towards the sexual openness of typically developing men and women. The data suggested that within the South Asian sample only, attitudes towards sexual openness in men was viewed more negatively than in

women. This is a novel finding that does not appear to be demonstrated in previous research. However, this finding is contrary with previous research which suggests women in South Asian cultures are expected to be more restricted in their sexuality compared to men (Ghule, Balaiah, & Joshi, 2007; Menon, 1989). Therefore, it is difficult to account for why sexual openness in men was viewed more conservatively than women only within the South Asian sample. As these comparisons were based on between subject effects, it is possible that other confounding factors between two groups of South Asians (for each questionnaire version) were not controlled for may account for the difference. This may include factors such as the degree that one practices their own religion and culture (these issues of religious and cultural affiliation are discussed further in section 4.4.2)

4.3.3: Attitudes towards the sexuality of men and women learning disabilities

Sexual Rights

The present study found that compared to White Westerners, people from South Asian backgrounds were significantly more negative in their attitudes towards the sexual rights of both men and women with learning disabilities. These differences in sexual rights attitudes between the two ethnic groups were evident even when the potential effects of attitudes towards sex in the typically developing population, education, occupation and recognition were added as covariates and controlled for in the analysis. This provided stronger support that the difference found was specifically concerned with the sexual rights of people with learning disabilities. Therefore, these findings fully supported hypothesis two.

One clinical implication that arises from these findings are that health and social care professionals may need to consider the potential for greater stigma and negative

attitudes towards sexual rights issues from families and carers of South Asian service-users with learning disabilities. Therefore, whilst there may be shame and embarrassment to talk openly about sexuality in general within South Asian communities, there appears to be a greater stigma, perhaps due to cultural beliefs, towards sexuality of people with learning disabilities. As this aspect of stigma is likely to occur within the immediate community of South Asian service-users, it can be regarded as public stigma (Ditchman et al., 2013). Self-stigma may then occur when the South Asian people with learning disabilities themselves internalise the public stigma leading to lower levels of self-esteem, anger and being complacent towards sexuality issues (Corringhan & Watson, 2002; Szivos-Bach, 1993).

One way of overcoming these challenges is for support to be available directly to service users, rather than via their families, although ethical and professional issues would need to be considered such as consent and capacity. Addressing sexual issues for South Asian people with learning disabilities may also be better approached via interventions involving education teachers and support workers. This is because sexuality is known to be not openly spoken about in South Asian families, especially between children and parents (Aziz & Maloney, 1985).

Non-reproductive sexual behaviour

No significant differences were found between White Westerners and South Asians in their attitudes towards non-reproductive sexual behaviour in both males and females with learning disabilities after controlling for covariates. This finding did not support hypothesis three and was surprising given that people from South Asian communities have been known to view sexuality as only part of a period of marriage when children are being conceived (Vatuk, 1985).

These findings may suggest that for South Asians residing within the UK, attitudes towards non-reproductive sexual behaviour in people with learning disabilities may have accommodated towards more Western liberal attitudes. Alternatively, the findings may suggest that White Westerners had more conservative attitudes in this area compared to other areas such as sexual rights, which lead to the lack of significant difference between the groups.

These findings are at first difficult to interpret, given that South Asian participants were found to have more conservative attitudes towards the sexual rights in people with learning disabilities, we would expect the same for non-reproductive sexual behaviour. However, when considering the actual questions asked within the non-reproductive behaviour scale, four out of the five questions within this scale referred to masturbation practices and one referred to homosexuality. Other aspects of sexual activity such as protected sexual intercourse were not captured and included as being "non-reproductive sexual behaviour" in contrast to the sexual rights scale asked questions concerning a broader range of sexual practise and issues. This helps clarify the findings and we can conclude that either people from South Asian background were less conservative in their attitudes towards masturbation and homosexuality or the White Western were more conservative in these areas compared to other areas such as sexual rights.

These findings contribute to the knowledge that South Asian and White Western communities may have differences in their attitudes towards sexuality in people with learning disability that are dependent on particular aspects of sexuality. This has practical implications for services when professionals deal with sexual issues, they may need to be aware of less or more conservative views of particular aspects of sexuality such as masturbation and homosexuality.

Parenting

It was hypothesised that compared to White Westerners, South Asian participants would have more positive attitudes towards parenting in men and women with learning disabilities. This was based on the previous literature which suggested that South Asian parents often wish to see their children with learning disabilities married and having children (Hepper, 1990; O'Hara & Martin, 2003; Summers & Jones, 2004; Baxter, 1990) and research on the typically developing population suggesting that South Asian communities view sexuality as an important part when having children within a marriage (Vatuk, 1985).

However, trends in the data from the present study indicated that South Asian participants were actually more negative compared to White Westerners in their attitudes towards parenting rights in men and women with learning disabilities. These trends are contradictory to the direction of the effect that was hypothesised. One way of interpreting these trends in the opposite direction to what was hypothesised, is that attitudes towards parenting in learning disability may only be more positive within a population of parents with a child with a learning disability, as has been suggested by the previous qualitative studies. The implication of this is that services may need to consider that even if family carers of a child with a learning disability are relatively positive in their attitudes towards them becoming a parent, they may still be stigmatised within their communities.

Significance of these trends was only achieved when univariate outliers were removed or when significance was considered at an uncorrected alpha level, Significance may have been achieved with a larger sample size, as after missing data procedures were employed for the parenting scale data, the number of South Asian participants fell below the calculated sample size that was required to detect an effect (n = < 70). This

was both for the South Asians that completed the male (*n* = 59) and female (*n* = 61) versions of the parenting scale.

Self-control

The present study also found that there was a non-significant trend in the data that suggested that men with a learning disability were viewed as having less self-control than females with a learning disability. This trend is consistent with what was hypothesised and previous findings (Cuskelly & Gilmore, 2007; Gilmore and Chambers 2010; Meaney-Taveres & Gavdia-Payne, 2012). These trends only partly supported hypotheses five, as significance was only achieved at the uncorrected alpha level for the post-hoc t-tests.

An important practical implication that arises from these findings include the need to challenge possible stereotypes that may exist regarding the ability for men with learning disabilities in being able to control their sexuality. Such stereotypes may originate from the historical Western beliefs that people with learning disabilities are a sexual threat to others due to their inability to control their sexual desires (McCarthy, 1999). Stereotypes have been known to be important for the development of public stigma (Jahoda et al., 2010; Fiske, 2012). One way of challenging stereotypes and stigma is to develop interventions that aim to educate people about the ability of men with varying degrees of learning disabilities to self-control their sexual desires.

4.4: Strengths, limitations and future directions

4.4.1: Strengths

The main strength of the present study is its contribution to the knowledge surrounding attitudes in the lay population towards the sexuality of men and women with learning disabilities. The present study was the first to quantitatively investigate differences that may exist in these attitudes between people in the lay population that are from White Western or South Asian backgrounds.

The study recruited relatively large sample sizes. Although the South Asian sample recruited was smaller than the White Western sample, the size can stil be considered an impressive size, given the well reported difficulties in recruiting people from minority ethnic backgrounds (Patel, Doku & Tennakoon, 2003). The study also used robust statistical procedures during the statistical analysis of its data including the use of parametric tests that have greater power. Family-wise error arising from multiple testing was protected against by adopting stringent adjustment of significant levels.

The present study also controlled for potential confounding factors by identifying unequally represented variables in the data that were known from previous research to influence attitudes towards sexuality. Such variables were entered as covariates in subsequent ANCOVA analyses. Such procedures have their strengths within statistical methods as a way of reducing error variance and elimination of confounds (Field, 2013). Another potential extraneous variable that was addressed in the present study is social desirability of responses. This was likely to be minimised given that the data was collected mostly online and in an anonymised form rather than by face-to-face interviews.

A further strength of the study is the use of qualitative data in order to supplement the quantitative analysis. Using such mixed methods has been argued to be a more rigorous and validating approach to interpretation data as the strengths and weaknesses of the quantitative versus qualitative approach offset each other (Creswell, 1999).

4.4.2: Limitations

As with any investigation, this research study is not without limitations. The present study has its limitations in terms of the effect sizes observed and the operationalization of concepts and the measures. The following section critically evaluates these limitations.

Whilst statistically, significant differences were found between the two ethnic groups on their mean scores for attitudes towards sexuality, such differences may not be clinically significant. This is because the effect sizes of differences between the two ethnic groups were small. Small effect sizes, even if statistically different may not represent any significant differences at face value clinically. Therefore, real life difference between people from South Asian backgrounds and White Westerners may not be particularly noticeable. The study findings therefore only represent small differences in sexual attitudes between the two ethnic groups, something that may not be noticeable or apparent in real life situations. Another limitation that was discovered post-analysis was the lack of collapsing of demographic variables for the chi-squared analyses. This would have produced the minimum number of values required within each category for chi-squared tests for some of the variables with low counts and would have aided interpretation of differences between the groups for the identified covariates.

Larger effect sizes between the two ethnic groups may be found in studies that continue to explore different factors related to sexual attitudes. One example of this may include comparing differences in attitudes towards sexual practices within and outside a marriage for people with learning disabilities. This is because South Asian communities view sexual behaviour within the typically developing population as important within a marriage solely for procreation (Vatuk, 1985). Therefore within the South Asian ethnic group, sex within marriage may not have the same taboos as other forms of sexual expression outside marriage, as has also been suggested by other studies (e.g. Baxter, 1994). The ASQ-ID and ASQ-GP measures used in this study are therefore limited in that they did not capture this culturally sensitive issue of whether the sexual behaviours and practices being described were being referred to within a marriage.

Another factor that may have been important within the present study was religion, although this was partly considered. This is because a statement of religion does not necessarily represent the degree of affiliation to this religion and conservative attitudes towards sexuality in the general population and towards people with learning disabilities have been associated with religious affiliation (De Visserur et al.; Saxe & Flanagan, 2014). Also, whilst the present study asked about participants UK length of residency and assessed for differences in this factor between the two questionnaire versions in order to control for the effects of acculutration, it has been argued that such measures do not capture the importance of heritage or mainstream culture for the individual (Meston & Ahrold, 2010). This is important for the South Asian ethnic group because the extent to which cultural practices are maintained have been found to vary extensively between individuals (Azmi et al., 1997 as cited in O' Hara et al., 2003).

There are also many limitations associated with online questionnaires, as was employed within the present study. As with any quantitative measures, the results can

only be interpreted with the assumption that the responses from participants are represented of their true beliefs. We can only also assume that each online questionnaire was only completed once by one adult that was either White Western or South Asian. Furthermore, the online questionnaire was only available in English and this may have been a barrier for older people or recent migrants in participating, resulting in a sample that is not representative of the wider population. This may explain why the older age group of South Asian participants were under-represented in the present study, although other reasons such as embarrassment regarding the topic may have also been factors.

The measure used to assess recognition in the present study can also be criticised. Whilst the vignette method used in the present study have been shown to be a reliable method in assessing recognition of a mild learning disability (Scior & Furnham, 2011), it is still questionable whether participants are able to fully conceptualise a mild learning disability from reading the vignettes used in this study. It is also possible that the changes made to the vignette in the present study to make them more gender and culturally neutral may have resulted in invalidating the original measure developed by Scior & Furnham (2011). Methods of recognition that use pictures and videos may provide more ecologically valid measures of recognition of mild-moderate learning disabilities.

The present study provided a definition of a learning disability after the recognition measure was administered. This procedure may in itself have resulted in more positive attitudes as it has been argued that lay people discriminate based only on observable behaviour as oppose to diagnostic categories (Scior & Furnham, 2011). This further suggests that pictures and videos of a person with a learning disability may have been a more valid method of assessing recognition of a learning disability and orientating people to their attitudes towards sexuality in people with learning disabilities. The

measure of prior contact in this study also did not appear a valid measure, as despite being shown the vignette and given an explanation of learning disabilities, participants stated prior contact with a person with a learning disability when in fact they were referring to related difficulties such a specific learning difficulty such as dyspraxia or Autisic Spectrum Disorders. This suggests a need to develop more reliable measures in assessing whether a person has had prior contact with learning disabilities.

Lastly, the present study can also be criticised in that South Asians were assumed to be one homogenous group when in reality this community compromises of people from a diverse range of historical, religious and cultural backgrounds. The same criticism can be applied to the “White Western” group, as although they were required to be living within the UK, included a small sample of people from American, Australian or European backgrounds.

4.4.3: Recommendations for future research

Based on the findings and limitations of the present study, a number of recommendations can be made for the direction of future research. These include exploring attitudes towards sexuality in people with learning disabilities between different ethnic groups and obtain larger sample sizes in order to compare different sub-ethnic groups (e.g. compare attitudes between people from Indian, Pakistani, and Bangladeshi backgrounds within the South Asian group).

Future studies may also want to investigate the influence of other factors on these attitudes such as religious and cultural affiliation. This can be achieved by developing scales with questions that ask about preferred language, and degree of which one identifies and practices their religion and culture. Future research in this area should

also discriminate between attitudes towards sexual behaviours both within and outside a marriage, as this is an important factor relevant to religion and culture.

Recognition of learning disabilities may also be better assessed in future studies with use of audio and video material. Studies may also wish to use such methods to ask about attitudes towards different severities of learning disabilities as the present study's findings were only applicable to people with mild-moderate learning disabilities. The present study's focus was also only on lay people's attitudes towards sexuality, which are important for understanding public stigma. However, in order to develop our understanding the effect of self-stigma and sexuality in learning disabilities, future studies may wish to investigate the attitudes towards sexuality from the perspectives of people with learning disabilities themselves.

Lastly, further research is required to explore how attitudes towards sexuality in other groups of people may differ compared towards people with learning disabilities. This may include, for example, people with physical impairments and people with mental health problems. This would allow the further development and comparison of conceptual models of stigma within contemporary societies.

4.5: Summary and Conclusions

This study has added to our understanding about lay people's attitudes towards sexuality in people with learning disabilities and how such attitudes may differ between people from South Asian and White Western backgrounds. The South Asian ethnic group were found to have significantly more negative attitudes towards the sexual openness in men and women within the typically developing population in addition to the attitudes towards sexual rights and parenting rights in males and females with learning disabilities. No difference was found in attitudes towards non-reproductive

behaviour in males and females with a learning disability between the two ethnic groups, although this may represent more liberal attitudes towards specific sexual practices such as masturbation and homosexuality within the South Asian group or more conservative attitudes in these areas within the White Western group. As with previous studies, there was a trend towards men being viewed as having less control than women within both ethnic groups. These findings, in addition to significantly lower rates of recognition of a mild learning disability found within the South Asian sample, have important clinical implications. These include the need for health and social care professionals to promote knowledge about learning disabilities (particularly for people from South Asian backgrounds), an awareness that conservative attitudes towards sexuality and stigma may be more prevalent in people from South Asian backgrounds and the need to address stigmatising sexuality stereotypes that may exist in both White Westerners and South Asians.

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APPENDIX 1

Confirmation of ethical approval

To:
nwjt074@rhul.ac.uk;
Theodore, Kate;
...
Cc:
PSY-EthicsAdmin@rhul.ac.uk;
Leman, Patrick;
...

Application Details:

Applicant Name:	**Deepak Sankhla**
Application title:	**Attitudes towards sexuality in people with learning disabilities: A comparison between two ethnic groups**
Comments:	Approved. Reviewers' comments below are for information. Reviewer 1. Ethical issues for this study have clearly been carefully considered, and I have only a few minor comments: Information sheet and consent form: Paragraph 1: perhaps change ‘and different groups of people’ to ‘and in different…’ for clarity. You could also consider mentioning that participants may omit specific questions if they wish (although it would be helpful if they could answer every question). It’s also not clear where participants register whether they are WB or SA – will this be on the demographics page? Reviewer 2. Cover page needs to mention that they can omit any questions they don't want to answer. Make sure the finished version without the track changes is used. Otherwise fine

APPENDIX 2

Male version of paper/online questionnaire

INFORMATION SHEET

Public Attitudes towards Sexuality and Parenting

My name is Deepak Sankhla and I am currently undertaking a study as part of my Doctorate at Royal Holloway, University of London. The study aims to further our understanding on how people from White and South Asian backgrounds view parenting and sexuality in different groups of people. This project is supervised by Dr Theodore and has been approved by the Psychology Department's internal ethical procedure at Royal Holloway, University of London.

We would like to invite adults (18+) to take part that are living in the UK and would describe their ethnicity as either WHITE or SOUTH ASIAN (Indian, Pakistani, Bangladeshi or Sri Lankan). This will involve completing an online questionnaire which asks about yourself and your views about parenting and sexuality. You will also be asked to read two short paragraphs of information. This should take approximately 10 minutes to complete.

Nobody except myself and my supervisor will be allowed to see your responses and you will be known only to us by a number. This will allow the information to remain completely confidential. Copies of this anonymous information may be made available to statutory and voluntary services, academic journals, brief reports and will be written up as a research thesis for my doctorate.

All information collected will be stored securely and will be destroyed when no longer required. You do not have to take part in this study if you don't want to. If you decide to take part you may withdraw at any time without having to give a reason. Whilst it would be very helpful for us if all questions are answered, you may omit questions you do not wish to provide an answer.

You are asked to provide your email address at the end of the questionnaire if you wish to enter the prize draw to win a £50 Amazon Voucher. Your email address will be stored on a separate document for the purposes of prize draw only and will not be used to identify your responses.

We highly appreciate your participation, because your contribution is important in developing the research in this area. There are no right or wrong answers or trick questions and we are keen to receive your honest opinions.

If you would like any further information please email either Deepak Sankhla(deepak.sankhla.2011@live.rhul.ac.uk) or Dr Theodore (Kate.Theodore@rhul.ac.uk)

CONSENT TO PARTICIPATE

By proceeding to the next page I confirm that I:

- agree to participate in the study
- belong to either a White or South Asian ethnic group
- am at least 18 years old
- have fully read the information on the previous page about the study
- know who to contact to answer any questions or for further information
- have understood that participation is voluntary and that I am free to withdraw from the study at any time, without giving a reason
- understand that there are not right or wrong answers and that all information collected will be anonymous
- understand that information will be kept securely and disposed of when no longer required

PARTICIPANT BACKGROUND DETAILS

Gender

- ☐ Male
- ☐ Female

What is your current relationship status?

- ☐ Single
- ☐ Married
- ☐ Civil Partnership
- ☐ Cohabiting
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

Please state you age:

…….

Do you have children (yes/no)?

……

Educational Level

- ☐ Left school before 16 (no qualifications)
- ☐ Secondary school (GCSE/equivalent)
- ☐ Higher Education (Sixth Form/ College/A-level or equivalent)
- ☐ Under-graduate degree level course
- ☐ Post-graduate degree level course

Please state your occupation

…….

Please tick the option that best describes your ethnicity (select one answer only)*

- ☐ White British
- ☐ White Irish
- ☐ Other/Mixed White*
- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Sri Lankan
- ☐ Other/Mixed South-Asian*

***If you selected "Other/Mixed White" or "Other/Mixed South Asian", please describe your ethnicity below:**

…….

Were you born in the UK (Yes/No)?

……..

If you answered no to the previous question, how long have you lived in the UK?

……

Religion:

- ☐ None
- ☐ Christianity
- ☐ Islam
- ☐ Judaism
- ☐ Hinduism
- ☐ Jainism
- ☐ Sikhism
- ☐ Buddhism
- ☐ Other, please specify

……

MALE SEXUALITY QUESTIONS

The following questions will be asking about your views only about male sexuality (both boys and men). We realise that your answers might be different if we asked about females but please think only about males here without making any comparisons.

There are no right or wrong answers and we are interested in your honest opinions. Your answers will remain anonymous (you will not be identified).

Please answer the following questions with respect to MALE SEXUALITY in the general population.

b. Boys should be discouraged from masturbating.

Strongly Disagree	Disagree	Mildly Disagree	Mildly Agree	Agree	Strongly Agree

c. Discussions on sexual intercourse promote promiscuity in boys.

Strongly Disagree	Disagree	Mildly Disagree	Mildly Agree	Agree	Strongly Agree

d. Sex education for boys has a valuable role in safeguarding them from sexual exploitation.

Strongly Disagree	Disagree	Mildly Disagree	Mildly Agree	Agree	Strongly Agree

e. Consenting male adults should be allowed to live in a homosexual relationship if they so desire.

Strongly Disagree	Disagree	Mildly Disagree	Mildly Agree	Agree	Strongly Agree

g. Advice on contraception should be fully available to young men.

Strongly Disagree	Disagree	Mildly Disagree	Mildly Agree	Agree	Strongly Agree

h. Sex education for boys should be compulsory.

Strongly Disagree	Disagree	Mildly Disagree	Mildly Agree	Agree	Strongly Agree

i. Masturbation in private is an acceptable form of sexual expression for men.

Strongly Disagree	Disagree	Mildly Disagree	Mildly Agree	Agree	Strongly Agree

CASE OF DYLAN

In this next section we are interested in whether people are able to recognise symptoms of a particular problem. The following page describes the case of Dylan. Please read this carefully:

Dylan is 22 and lives at home with his parents and younger brother. He found school a struggle and left without any qualifications. He has had occasional casual jobs since. When his parents try to encourage him to make plans for his future, Dylan has few ideas or expresses ambitions that are well out of his reach. Rather than having him at home doing nothing his parents have been trying to teach Dylan new skills, so he can help with some tasks in the family business, but he has struggled to follow their instructions. He opened up a bank account with his parents' help, but has little idea of budgeting and, unless his parents stop him, Dylan will spend all his benefits on comics and DVDs as soon as he receives his money

What do you think, if anything, is wrong with Dylan?*

……

……....

LEARNING DISABILITY

Dylan is a person with a mild learning disability. People with learning disabilities are also sometimes referred to as ‘mentally handicapped.’ The term 'intellectual disability' is also used.

Having a learning disability affects the way a person understands information and how they communicate. This means they also have difficulties with daily living such as:

- looking after themselves, getting dressed, going to the bathroom, preparing food

- social skills with peers, family members, adults and others

- attending mainstream schools (they may have attended a special school or needed extra help at school)

- **Have you ever met someone with a learning disability (yes/no)?**

…….

- **If you have answered yes to the previous question, can you state in what capacity (e.g. family, neighbour, friend) you have known/met a person with a learning disability:**

……

SEXUALITY IN MALES WITH A LEARNING DISABILITY

The following questions will be asking about your views only about male sexuality (both boys and men). We realise that your answers might be different if we asked about females but please think only about males here without making any comparisons.

There are no right or wrong answers and we are interested in your honest opinions. Your answers will remain anonymous (you will not be identified).

Please answer the following questions with respect to sexuality in males with a mild to moderate learning disability.

1. With the right support, men with a learning disability can rear well-adjusted children.

Strongly Disagree	Disagree	Mildly Disagree	Mildly Agree	Agree	Strongly Agree

2. Provided no unwanted children are born and no-one is harmed, consenting adult men with a learning disability should be allowed to live in a heterosexual relationship.

Strongly Disagree	Disagree	Mildly Disagree	Mildly Agree	Agree	Strongly Agree

3. Consenting men with a learning disability should be allowed to live in a homosexual relationship if they so desire.

Strongly Disagree	Disagree	Mildly Disagree	Mildly Agree	Agree	Strongly Agree

5. Men with a learning disability have less interest in sex than do other men.

Strongly Disagree	Disagree	Mildly Disagree	Mildly Agree	Agree	Strongly Agree

6. If men with a learning disability marry, they should be forbidden by law to have children.

Strongly Disagree	Disagree	Mildly Disagree	Mildly Agree	Agree	Strongly Agree

8. Medication should be used as a means of inhibiting sexual desire in men with a learning disability.

Strongly Disagree	Disagree	Mildly Disagree	Mildly Agree	Agree	Strongly Agree

9. Masturbation should be discouraged for men with a learning disability.

Strongly Disagree	Disagree	Mildly Disagree	Mildly Agree	Agree	Strongly Agree

10. Discussions on sexual intercourse promote promiscuity in men with a learning disability.

Strongly Disagree	Disagree	Mildly Disagree	Mildly Agree	Agree	Strongly Agree

11. Men with a learning disability should only be permitted to marry if either they or their partners have been sterilized.

Strongly Disagree	Disagree	Mildly Disagree	Mildly Agree	Agree	Strongly Agree

12. Masturbation in private for men with a learning disability is an acceptable form of sexual expression.

Strongly Disagree	Disagree	Mildly Disagree	Mildly Agree	Agree	Strongly Agree

13. Men with a learning disability typically have fewer sexual interests than other men.

Strongly Disagree	Disagree	Mildly Disagree	Mildly Agree	Agree	Strongly Agree

15. Men with a learning disability are unable to develop and maintain an emotionally intimate relationship with a partner.

Strongly Disagree	Disagree	Mildly Disagree	Mildly Agree	Agree	Strongly Agree

16. Sex education for men with a learning disability has a valuable role in safeguarding them from sexual exploitation.

Strongly Disagree	Disagree	Mildly Disagree	Mildly Agree	Agree	Strongly Agree

17. In general, sexual behaviour is a major problem area in management and caring for men with a learning disability.

Strongly Disagree	Disagree	Mildly Disagree	Mildly Agree	Agree	Strongly Agree

18. Sexual intercourse should be permitted between consenting adults with a learning disability.

Strongly Disagree	Disagree	Mildly Disagree	Mildly Agree	Agree	Strongly Agree

19. Group homes or hostels for adults with a learning disability should be either all male or all female, not mixed.

Strongly Disagree	Disagree	Mildly Disagree	Mildly Agree	Agree	Strongly Agree

20. Care staff and parents should discourage men with a learning disability from having children.

Strongly Disagree	Disagree	Mildly Disagree	Mildly Agree	Agree	Strongly Agree

22. Men with a learning disability have the right to marry.

Strongly Disagree	Disagree	Mildly Disagree	Mildly Agree	Agree	Strongly Agree

23. It is a good idea to ensure privacy at home for men with a learning disability who wish to masturbate.

Strongly Disagree	Disagree	Mildly Disagree	Mildly Agree	Agree	Strongly Agree

25. Sexual intercourse should be discouraged for men with a learning disability.

Strongly Disagree	Disagree	Mildly Disagree	Mildly Agree	Agree	Strongly Agree

26. Advice on contraception should be fully available to men with a learning disability whose level of development makes sexual activity possible.

Strongly Disagree	Disagree	Mildly Disagree	Mildly Agree	Agree	Strongly Agree

27. Men with a learning disability are more easily stimulated sexually than people without a learning disability.

Strongly Disagree	Disagree	Mildly Disagree	Mildly Agree	Agree	Strongly Agree

28. Marriage between adults with a learning disability does not present society with too many problems.

Strongly Disagree	Disagree	Mildly Disagree	Mildly Agree	Agree	Strongly Agree

29. Sterilisation is a desirable practice for men with learning disabilities.

Strongly Disagree	Disagree	Mildly Disagree	Mildly Agree	Agree	Strongly Agree

31. Masturbation should be taught to men with a learning disability as an acceptable form of sexual expression in sex education courses.

Strongly Disagree	Disagree	Mildly Disagree	Mildly Agree	Agree	Strongly Agree

32. Marriage should not be encouraged as a future option for men with a learning disability.

Strongly Disagree	Disagree	Mildly Disagree	Mildly Agree	Agree	Strongly Agree

33. Men with learning disabilities should be permitted to have children within marriage.

Strongly Disagree	Disagree	Mildly Disagree	Mildly Agree	Agree	Strongly Agree

34. Men with a learning disability have stronger sexual feelings than other men.

Strongly Disagree	Disagree	Mildly Disagree	Mildly Agree	Agree	Strongly Agree

Are there any other comments you would like to make about the sexuality of males with a learning disability?

……..
……
……
……..

Thank you participating in this project.

If you have any further questions or comments you can email either

Deepak Sankhla
(deepak.sankhla.2011@live.rhul.ac.uk).

or

Kate Theodore
(Kate.Theodore@rhul.ac.uk)

If you wish to be entered into a prize draw to win a £50 Amazon voucher, please provide your email address below. Your email address will be stored on a separate document for the purposes of the prize draw only and will not be used to identify your previous responses.

APPENDIX 3

Sample Online Recruitment Advert

Answer some questions to enter a prize draw to win a £50 Amazon voucher!

"A study assessing public attitudes towards sexuality and parenting"

I am a doctorate student looking for anyone who is aged 18+ living in Britain that would describe themselves as either from a White or South Asian ethnic background to take part in my research project. This involves completing a questionnaire online that will take around 10 minutes. You can provide your email the end to enter the prize draw.

Please click on the link below to take part:

http://www.pc.rhul.ac.uk/sites/surveys/TakeSurvey.asp?SurveyID=4J3l563I2n92G

I would be very grateful if you could share this message onto family and friends

APPENDIX 4

Original Vignette (Scior & Furnham, 2011)

Vignette 1 - Mild Intellectual Disability

James is 22 and lives at home with his parents and younger brother. He found school a struggle and left without qualifications. He has had occasional casual jobs since. When his parents try to encourage him to him to make plans for his future, James has few ideas or expresses ambitions that are well out of his reach. Rather than having him at home doing nothing, his mum has been trying to teach James new skills, such as cooking a meal, but James has struggled to follow her instructions. He opened up a bank account with his parents' help, but has little idea of budgeting and, unless his parents stop him, will spend all his benefits on comics and DVDs as soon as he receives his money.